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HCFA MARKET RESEARCH FOR BENEFICIARIES

FIRST INVENTORY REPORT
GENERAL MEDICARE POPULATION

VOLUME II

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HEALTH CARE FINANCING ADMINISTRATION
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EXECUTIVE SUMMARY

As Medicare beneficiaries continue to confront a variety of changes within the health care delivery system and information technology continues to advance, the Health Care Financing Administration (HCFA) faces the challenge of adapting its operations and communication strategies to better serve its customers and partners. This effort is particularly important because the communication environment is rapidly changing in three important ways: 1) messages about insurance and health care delivery are becoming increasingly complex; 2) important difficult-to-reach market segments defined by language abilities, culture, and functional status are emerging as the elderly population grows and diversifies; and 3) exciting communication technologies offer new possibilities that can be effectively harnessed and then diffused, both directly to beneficiaries and to the broad range of providers in need of HCFA-relevant information. Results of the market research will assist HCFA in upgrading its current communication strategies to incorporate innovative technologies and systems.

This inventory report is the first in a series of studies for the HCFA's Market Research for Beneficiaries project. The project is designed to assist HCFA to better understand the information needs of its primary customers--Medicare beneficiaries--and to identify the best strategies for communicating that information to them. By providing the right information about the Medicare program in formats that are easily understandable by beneficiaries, HCFA can assist them in making the best choices among health care delivery systems, providers, and treatment options, and in using the Medicare program effectively. The project utilizes three complementary data collection strategies: an inventory of existing communication strategies; focus groups with Medicare beneficiaries and related groups; and surveys of beneficiary populations.

This first report summarizes the findings from the project inventory which focused on information needs and communication strategies for the general Medicare population. Subsequent data collection will focus on specific segments of the beneficiary population that may have special information needs or require tailored communication strategies, such as beneficiaries with disabilities. Inventory research is a good vehicle for taking stock of what is currently known about a topic. The information synthesized in this report was obtained from two sources: a review of the relevant communications literature with an emphasis on the special needs of the Medicare population; and a series of interviews with organizations that have experience with Medicare beneficiaries or have used innovative communication strategies.

The project is designed to help HCFA understand the flow of information about Medicare between itself and beneficiaries. The following two questions are the focus of the market research:

- What information do beneficiaries want and need from HCFA?
- How can that information be most effectively made available?

The specific goal of this project is to provide HCFA with an understanding of the needs of Medicare beneficiaries by synthesizing data from three sources: (1) an inventory of information

needs and effective communication strategies of a variety of organizations, (2) focus groups with Medicare beneficiaries, and (3) surveys of the Medicare population. The data collection strategies are complimentary and each has particular strengths. Taken together, they will provide HCFA with an understanding of communication with Medicare beneficiaries that is broad in scope, deep in content, and representative of the population.

The inventory component is central to the project's success. It provides HCFA with a global picture of current and emerging methods and strategies for determining beneficiary information needs and for disseminating materials to beneficiaries on both the Medicare program and general health concerns. Inventory research is a good vehicle for taking stock of what is currently known about a topic. There are two major parts of the inventory: a review of the literature, and a series of interviews with key individuals in organizations that have experience understanding Medicare beneficiaries' information needs and that have implemented a variety of innovative communication strategies.

The project will produce a series of inventory reports. The focus of this first report is the general Medicare population. Subsequent reports will focus on beneficiary subgroups of particular interest to HCFA. The purpose of this first Inventory Report is to synthesize the most important observations and findings from the literature review and interviews in order to inform the development of effective communication strategies that are responsive to the needs of Medicare beneficiaries. Optimal use of the Medicare program is dependent upon beneficiaries having the information to enable them to clearly understand the most relevant features of the program. Only then can they make the best possible choices, based on their preferences, among a variety of providers and insurance arrangements.

Following is a synthesis of our findings on beneficiary information needs, the processes used by organizations to discover them, and "best practices" for communicating information on Medicare and staying healthy. Major findings from the inventory are presented below, and are organized by beneficiary information needs, methods of determining those needs, and communication strategies.

Information Needs of Medicare Beneficiaries

Both the literature review and the interviews indicate multiple deficiencies in beneficiaries' knowledge of the Medicare program. Research indicates that 25 percent or more of Medicare beneficiaries lack a basic understanding of the program, and there is some indication that many of those who reported familiarity with basic Medicare terminology had only a superficial knowledge. The problem of inadequate knowledge is more severe for specialized parts of the program such as managed care, supplemental insurance, and coverage of preventive health services. Several pieces of information from the literature review help illustrate the knowledge gap:

- Nearly one quarter of beneficiaries who had been hospitalized did not understand which hospital charges Medicare had paid;
- Two-thirds of beneficiaries did not know that Medicare pays for a second surgical opinion;
- Fewer that one-in-seven eligible beneficiaries knew about the Qualified Medicare Beneficiary program;
- As many as 13 percent of beneficiaries have unneeded multiple supplemental insurance policies;
- Recent focus groups indicated that few beneficiaries knew how managed care operates within Medicare;
- Only seven percent of beneficiaries were aware of quality data published by HCFA on hospital-specific mortality rates; and
- Many beneficiaries believe the Social Security Administration, rather than HCFA, runs the Medicare program.

Major findings of the inventory include the following:

- Information needs vary depending upon a variety of factors, both specific to the beneficiary and in the surrounding environment. Examples include timing, health status of the beneficiary, and the characteristics of the local managed care market. In general, beneficiaries who are sick or manage chronic conditions, as well as individuals who live in areas with highly developed managed care markets, are the most knowledgeable about Medicare.
- Information should be available at the time it is needed, that is when beneficiaries must interact with the program (enrollment, use of services, payment for services). The information beneficiaries want at any time relates specifically to the situation they are currently facing. Beneficiaries need different types of information at different points during the time that they are covered by Medicare. The information needs to be clear, simple, and to the point.
- The literature reports that although many beneficiaries may understand the major features of their coverage, there are gaps in their understanding, especially of services that are infrequently used (such as long-term care, second surgical opinion, or coverage of durable medical equipment). Minorities/low-income beneficiaries (especially recent immigrants) are confused by the plurality of the American health system and the ways that different components (e.g., different sources of payment for services) interact.
- An important information gap relates to managed care options. First, some beneficiaries do not see the distinction between the two systems: fee-for-service and managed care. They equate Medicare managed care with traditional Medicare plus supplemental insurance. Second, many beneficiaries do not understand the unique features of managed care that will affect their costs and their ability to access certain health services. For example, some beneficiaries do not realize that a "zero dollar premium" for some HMOs does not eliminate the required Part B premium payment to HCFA.
- The most frequently mentioned concern of beneficiaries is cost. To beneficiaries, "cost" includes premiums, deductibles and coinsurance, limiting charges, and Medicare-approved charges. Beneficiaries have two basic questions about cost: "How much will I have to pay for

a service?" and "Why do I have to pay, I thought Medicare covered it." Often beneficiaries are unsure of the portion of the bill paid by Medicare and the portion of the bill that must be paid by themselves or other insurance (employer-based, Medigap, Medicaid). From the interviews, it was clear that confusion about the cost issue is usually due more to a lack of understanding than a lack of information.

- Medicare beneficiaries, like the general public, tend to define "quality" in terms of aspects that are most important to them in health care: their physicians, and their own experience of receiving care. Factors such as whether the provider listened to them, or whether they had to wait a long time before being seen might be more relevant to beneficiaries than some of the more abstract quality measures used in health services research.

Gathering Feedback and Assessing Information Needs

Understanding and meeting the needs of beneficiaries, or more broadly, of customers, is important to the success of an organization in serving its target population. We found a range of strategies for identifying and gathering information on the needs of customers used by the organizations we interviewed, ranging from informal staff discussions to regular written reports and a formalized management structure allocated to the function. We also found evidence of both proactive strategies (such as surveys and focus groups) and reactive strategies (responding to customer inquiry). The most important findings from the inventory are:

- Generally, more formal and proactive information gathering processes were used by large, innovative organizations that seek to include customer feedback into their quality management activities.
- Effective organizations use formal, proactive research methods, such as focus groups and surveys, throughout the quality management cycle, not just at project inception or implementation review.
- For a program as large and complex as Medicare, both formal/proactive and informal/reactive information gathering strategies are required. To be successful, it is essential that HCFA **partner** with community-based organizations, such as those supported by United Way and the Alliance for Information Referral Systems, in order to take advantage of their day-to-day in-person/informal contacts with seniors and the information they routinely gather.
- To successfully use information that is obtained from customers it is necessary to incorporate it into ongoing business operations. Unless there are formal and consistent mechanisms to use customer feedback and information, timely organizational responses are unlikely and customer service may improve more slowly.
- The appropriate strategy for information gathering depends on the mission of the organization, purpose for the information, and level of resources. Proactive processes are used when organizations are developing an overall strategy; reactive processes are used to tweak the system and be responsive to customers who had initiated contact.

Communication Strategies

Both the literature review and the many interviews provide a wealth of information on effective strategies for communicating complex information, particularly about health benefits and health promotion. Although much of what we learned through the interviews is specific to Medicare beneficiaries, we saw effective communication strategies for other populations directly relevant to the Medicare population. Private companies and Federal agencies, in particular, provide examples of techniques used effectively with employees, retirees, and program participants to communicate information on health benefits, program eligibility, and to address participant questions. The most important results of the inventory in terms of "best practices" for communicating with beneficiaries relate to message content and format, or message dissemination.

General Principles

- **Target Distribution** - A general principle of marketing and a main finding of this Inventory Report is that beneficiaries need and want information that is relevant to them. Most people do not utilize information until it is necessary to resolve a problem or make a decision. Timing of information delivery often determines whether or not the receiver will pay attention to it. For example, those about to enroll may need and be able to attend to limited information on the basics of Medicare, how and when to enroll, and the basic choices that individuals will have to make at the time of enrollment. Directing information to those who might need it also helps ensure that it will be attended to, such as an HMO sending flyers about an upcoming healthy heart program to members who have had cardiovascular surgery.
- **Diversify and Sustain Communication Activities** - Providing information using a variety of communication tools allows beneficiaries to access it by using their strongest or preferred learning style. An example would be to use printed materials, video, and personal instruction, all on the same topic. Or use a single vehicle to raise awareness first, followed by a separate vehicle to convey detailed information. Each method will strengthen and reinforce the message delivered by the others. One-on-one communication, though logistically difficult, is the most effective communication strategy for most individuals. The size of the beneficiary population constrains this as a primary strategy, but it can be powerful combined with other methods. Also, HCFA can partner with organizations that work regularly with seniors who can deliver this most effective method of communication.
- **Partner with Local Organizations** - Leverage resources by partnering with local or regional organizations, especially those that have already established networks within the community.
- **Simplify Concepts** - Before any text is written, the material to be communicated should be broken down into its component ideas, and organized in basic conceptual "chunks". This allows the audience to identify each basic concept around which more detailed and complex information can then be presented. Simplification to a basic or concrete level is crucial for successful and effective transmission of confusing and abstract information, such as health insurance.
- **Simplify Language** - Avoid technical language, jargon, and difficult words. Use active voice and simple sentence structure. Highlight major issues using short sentences and elaborate on

confusing issues. For example, when insurance terms must be used, provide a clear explanation, either in a glossary, within the text, or in a margin. Write text for the average reader rather than for the average health services researcher. This not only includes word choice, but the layout of the words on the page.

- **Facilitate Access** - Confusion over health insurance often results from a lack of certain pieces of information as well as a misunderstanding of available information. Communication tools should be developed that are consistent with the target audience's level of comprehension and ability to access the information and address the barriers faced by beneficiaries.
- **Simplify the Interaction** - We found that providing a simple process for the beneficiary to arrive at the appropriate information source reduces confusion and facilitates comprehension of the information. This principle is akin to "one-stop-shopping."

Illustrative Specific Findings

Although the details of specific communication strategies and various "do's" and "don'ts" are found throughout this Inventory report, the following highlight some of the most important of our findings.

- Person-to-person, community-based communication, especially by knowledgeable and trusted individuals or organizations are most important, especially for racial and ethnic minority populations. These populations often have language and cultural barriers to general communications, and may also exhibit distrust of non-community-based efforts. Furthermore, communication should be tailored to the level of the recipient's knowledge, addressing the particular information gaps and sources of misunderstanding identified for the population.
- Different communication strategies are required for "forced" events (enrollment, plan choice, use of acute care services such as a hospitalization) and "voluntary" events (use of preventive services such as influenza immunizations).
  - For "forced" events, clear, concise general information is required at the time of the event, and HCFA and its partners must be able to provide tailored, issue- specific answers to the inevitable questions that will arise as beneficiaries come into contact with various health systems and the Medicare program.
  - Effective communication for "voluntary" events is both more difficult and more costly. Therefore, these efforts must be carefully targeted by HCFA. To be effective, HCFA must integrate a variety of strategies in a manner appropriate to the target audience. For example, research has shown that effective strategies for increasing the use of specific prevention services rely on a coordinated combination of televised public information spots, poster/billboards in places frequented by seniors, personal contacts with high risk beneficiaries by a health professional or health plan, and follow-up contact. HCFA has been especially successful with its flu and mammography campaigns. Because of the expense of this combination of techniques, however, it is essential to leverage HCFA resources with those of its community partners.

- Printed material will continue to provide a major vehicle for Medicare information over the next decade. Keys to effective printed material for the elderly include using bullets and short sentences, large readable print, plenty of white space on the page, avoidance of jargon or highly technical terms, easy to understand charts and pictures, clear contrast in colors used in text, use of tabs and indices, and a layered approach with more detailed information building on and consistent with the summary information.
- Videos can have a specific structure, should be time limited, and should include a written supplement. Videos are most powerful when they use "people like me" and clearly communicate their purpose. They can serve as an effective compliment to an overall public information campaign, for example, a campaign to encourage the use of preventive services. Videos can also be effective training materials for beneficiaries or those who work with them who use videos as a source of information (see below).
- Most large, innovative companies have instituted a single 1-800 number for all health benefits information. Both the literature review and interviews suggest that Medicare beneficiaries would like to see a single 1-800-CALL-MEDICARE type of number. The elderly prefer that a person answer their call, rather than an automated voice tree. However, given the expense, what appears most important is that the caller get to a person quickly, that the first individual spoken to be able to answer most questions directly, and that any referral be made within the call, thus a seamless process for the caller. One large company uses separate toll free numbers for younger and older callers, with a trained human operator for retirees over 80 years of age.
- Medicare beneficiaries receive information about the program from a variety of sources including HCFA materials, friends and family, healthcare providers, senior groups, churches and civic organizations, and their health plans. A key to an effective communication strategy for HCFA is to ensure that all of these potential sources of information have good, clear, and correct information to provide when asked. Training of volunteers, informational brochures and training for managed care plans and primary care physicians and their office staff (nurses and office administrators), etc. can both leverage HCFA's limited resources, and ensure that information provided by the many sources used by beneficiaries clarifies rather than confuses the issues.
- New communication technologies are most effective when they resemble the one-on-one interactive communications preferred by Medicare Beneficiaries. Examples of interactive electronic strategies include: CD ROMs with interactive software devoted to specific chronic conditions; on-line user groups or forums devoted to particular illnesses or conditions; and continually updated lists of frequently asked questions (FAQs) about Medicare or chronic health conditions.

HCFA is already involved in many initiatives and ongoing activities that address many of the issues identified in this report, such as the redesign of selected print materials and improving the Insurance Counseling and Assistance (ICA) grants program. Findings on the information needs and effective communication strategies obtained through the review of the literature and the many interviews we conducted, all contribute significantly to HCFA's strategic vision of improving service to its primary customer: the Medicare beneficiary. The future work of the Market

Research team through subgroup inventories, extensive focus groups with both the general Medicare population and population subgroups, and the analysis of the planned national surveys will further strengthen the platform of information on which HCFA plans to build its customer service activities.

Summary

The Inventory Report presents the findings from a review of the literature and interviews conducted with approximately seventy individuals from diverse organizations regarding the information beneficiaries need and want, and "best practices" for communicating complex information. In short, Medicare beneficiaries want information that is relevant to their situation, presented in a way that is easily comprehended and within the framework of their particular circumstance.

It is hoped that this research will provide a concise yet detailed picture of the information needs of Medicare beneficiaries, and how best to communicate that information. The work is applicable not only to HCFA, but to any organization in the process of designing an integrated communication strategy to reach a target audience with a complex message.

PROJECT OVERVIEW AND FRAMEWORK FOR THE INVENTORY

Background

As Medicare beneficiaries continue to confront a variety of changes within the health care delivery system and information technology continues to advance, the Health Care Financing Administration (HCFA) faces the challenge of revising its operations and communication strategies in order to better serve its customers and partners. This shift will enable HCFA to address an increasingly diverse beneficiary population, and prepare for the needs of the "baby boom generation," the first of whom will become eligible for Medicare shortly after the turn of the century. In addition, general information on health insurance and on Medicare, in particular, has increased in volume and complexity, requiring a sophisticated knowledge of finance and health care service delivery. These changes and difficulties significantly impact the nation's elderly and disabled, as many beneficiaries will be making fundamental decisions about health care benefits and require a proper understanding of the Medicare program and the options available to them to make good decisions.

In addition, the health care marketplace and the Medicare program itself are evolving. The fee-for-service system that has characterized the financing of health care in the United States is rapidly being replaced by a system in which health plans and other payers are managing the health care received by members: through increasing oversight on utilization; tracking, measuring and assuring quality; and encouraging the use of preventive health services to promote healthier members. In response to these and other changes, HCFA has developed a strategic plan to move the agency from being an organization primarily focused on processing and paying claims to an organization that emphasizes service to its customers as the core of its mission. HCFA is attempting to improve its service to its customers and partners and to promote effective utilization of the Medicare program. Through this effort, the Agency will revise its current communication strategies while incorporating innovative technologies and systems. The four components of the initiative include: (1) identifying the information needs of HCFA customers through market research; (2) improving the usefulness of HCFA data and information; (3) enhancing communications capabilities; and (4) developing formal evaluation and feedback mechanisms to ensure continuous improvement of HCFA activities.

Overview of Market Research for Beneficiaries Project

The Market Research for Beneficiaries project is dedicated to helping HCFA understand the information flow between itself and beneficiaries. The following two questions are the focus of the market research:

- What information do beneficiaries want and need from HCFA?
- How can that information be most effectively made available?

The specific goal of this project is to provide HCFA with an understanding of the information needs of Medicare beneficiaries and effective communication strategies through a series of data

collection activities and analyses. The three data collection activities that are used include an inventory of information needs and effective communication and dissemination strategies, focus groups with Medicare beneficiaries, and surveys of the Medicare population. While complimentary, each data gathering approach has particular strengths that will contribute to a more thorough overall understanding of the research questions. For example, the surveys of Medicare beneficiaries help ensure that the information gathered is representative of Medicare beneficiaries, while the focus groups contribute more in-depth of information than can be obtained from large-scale surveys.

The inventory component is central to the project's success and serves several purposes, including guiding the design of the focus group protocols and survey questions. The inventory provides HCFA with a blueprint of current and emerging methods and strategies for determining information needs and disseminating the details of the Medicare program and general health information to beneficiaries. The two components of the inventory are: a review of the literature on information needs and effective communication strategies for Medicare beneficiaries; and a series of discussions with key individuals in organizations that have experience in understanding consumers' information needs regarding health insurance plans and benefits, as well as experience with a variety of communication strategies. Organizations that have provided input for the inventory include HCFA central and regional offices; private corporations; social service organizations that work directly with seniors; organizations representing or advocating for minority or other special population groups; federal agencies administering benefit programs with large numbers of participants (e.g., Social Security, Food Stamps); Medicare and Medicaid carriers, intermediaries, and managed care plans; and individual researchers who are experts in the area of health communications. The inventory provides the best available information from published research and the practical experience of organizations and individuals engaged in communications on a day-to-day basis.

The second component of the market research is the design, conduct, and analysis of focus groups of Medicare beneficiaries. Focus groups provide the opportunity to gather in-depth information and to probe for clarification of issues and resolution of seemingly contradictory information. Focus groups can also be targeted to include particular groups of the population that are of special interest.

The third component or data source is the addition of supplemental questions to the Medicare Current Beneficiary Survey (MCBS), and the fielding of supplemental surveys for special populations, such as individuals about to enroll in Medicare. The surveys are designed to yield nationally representative, statistically reliable data on individuals' knowledge of the Medicare program, sources of program information, requirements for Medicare and health-related information, and preferences on ways in which they would like to receive information. The survey sample sizes will be sufficient to permit analysis of the special needs of subgroups of the Medicare population including racial and ethnic minorities, the disabled, low-income individuals, and those that may face language barriers to effective communication.

In order for HCFA to respond to the varying needs of a diverse Medicare population, the Market Research for Beneficiaries project will be conducted in two phases. The first, and the subject of this report, will focus on the general Medicare population, taking inventory of broad based communication strategies and understanding the general needs of Medicare beneficiaries. This report will be followed by general Medicare population reports based on focus group and survey data analysis.

Recognizing that certain Medicare beneficiaries have special communication needs, the second phase of the project will focus on collecting data on the information needs and most effective communication strategies for reaching subgroups of the Medicare population. Currently, these will include the following eight subgroups:

1. People about to enroll in Medicare;
2. African Americans;
3. Hispanic/Spanish speaking;
4. Dually enrolled in Medicare and Medicaid;
5. Low education;
6. Beneficiaries living in rural areas;
7. Visually impaired; and
8. Hearing impaired.

The Market Research for Beneficiary project staff will complete separate inventory, focus group, and survey reports for groups of Medicare subpopulations. At the end of the project, summary recommendation reports will be completed that will synthesize the information from the different reports.

Communicating with Medicare Beneficiaries: Conceptual Overview

The role of information is central to effective consumer decisionmaking. Considerable economic research has shown that in order for a competitive market to operate efficiently, consumers must have the necessary information to make choices that best match their preferences and needs, within the limits of their ability and willingness to pay. However, many economists, researchers, and policy makers have concluded that the market for health services functions inefficiently. Most agree that a primary reason for this "market failure" is lack of information--consumers are often uncertain about the occurrence of, and costs of, illness; often are not aware of appropriate and efficacious medical treatment; and are often influenced unduly by emotional factors unrelated to the treatment. This asymmetry of information has resulted in the delegation of considerable power to physicians and other providers to determine the quantity and mix of health services, which further complicates consumer decisionmaking.

In a market that is operating efficiently, sellers use resources rationally to produce goods and services, primarily due to the competitive pressure of many other sellers. This competition ensures that the prices of goods and services are as low as possible. Economists and others cite the rapid increases in the price of health care as one piece of evidence that the market does not function

efficiently. Third party payment (or insurance) for health services has further removed price as a mechanism for allocating goods and services, and contributed to the transfer of decisionmaking from the consumer to the provider. The provision of adequate information serves to counter these factors, and restore price as a mechanism for determining allocation, and the consumer as the primary decisionmaker.

Information and Communication Theory

HCFA is interested in improving the flow of information to its beneficiaries to enable them to use the program more effectively, to reduce beneficiaries' uncertainty about the program, and to promote the health of the elderly. The project team relied on the considerable research that has been conducted on communication theory to help structure our review of the literature and to develop the protocols for the interviews. The two most important theoretical formulations that were used in developing this research were Consumer Information Processing Theory and Social Marketing Theory. The following sections summarize these theories and indicate how they guided the inventory component of the HCFA Market Research for Beneficiaries project.

Consumer Information Processing Theory. Consumer Information Processing Theory (CIP) is part of the domain of cognitive psychology, and seeks to explain what goes on in a consumer's mind by drawing on theories of cognition, decisionmaking, and behavior change. Under CIP, consumer choice or decisionmaking is a multi-step process, involving the following elements:

- Information processing capacity;
- Motivation;
- Attention and perception;
- Information acquisition;
- Decision rules and processes; and
- Learning.

Simply making information available to people is not sufficient for effective decisionmaking. They have to attend to the information, and in order for them to attend, they must be motivated and able to take in the information.

Two premises underlie CIP. First, individuals processing information are limited by both their capacity to store information in short term memory and their ability to transfer it to long term memory. Second, information processing produces cumulative learning, which affects future information-seeking behavior. The relevance of these premises to this initiative is the importance of presenting information in readily digestible, easily remembered packages, and the fact that for the beneficiary, each round of processing a piece of information influences subsequent rounds. In other words, success in understanding the first piece of educational material concerning Medicare creates motivation to acquire further information, whereas initial beneficiary confusion can perpetuate further confusion and discourage information-seeking behavior. Methods of presenting information on Medicare should include a layered approach, whereby minimal information is

presented very simply at first, so the individual can be "successful" in understanding it. This early success increases the probability that the individual will remain motivated to learn more, and creates cognitive "hooks" on which to hang subsequent, more complicated information.

One implication of the limitations of the human psyche in the processing of information is that an individual will use certain cognitive techniques to enhance the utility of the information he or she has been able to acquire. For example, an individual might use the technique of "chunking," which is a way of integrating a number of simple and related bits of information into higher-order, more meaningful, information "chunks" (Simon, 1979).[1] Information "chunks" are familiar configurations of information that greatly increase the capacity of the short term memory (Newell and Simon, 1972).[2] This cognitive shortcut is one way an individual can increase his or her ability to remember and store the material.

A second implication of CIP is that there are several essential conditions that enable consumers to make use of information: the information must be considered useful and it must be processable within the time, energy, and comprehension level of the consumer (Rudd and Glanz, 1990).[3] In other words, the Medicare beneficiary must want the information because it is relevant to him or her, be able to access and process it, and see how it can be used in his or her life.

Social Marketing Theory. Many of the marketing principles used with consumer products can be applied to social issues and ideas, which can be somewhat abstract and often are intangible. Social marketing is "the design, implementation, and control of programs that are seeking to increase the acceptability of a social idea or practice in a target group or groups" (Kotler, 1982).[4] Social marketing theory categorizes the forces at work as environmental influences (such as one's cultural context), and individual influences (primarily one's learned behaviors and attitudes). Marketing itself is based on exchange theory, in which an individual pays a price (in money, time, or other resources) and, in return, receives a benefit (a good, service, or idea).

Most marketing models use carefully targeted strategies to create voluntary exchanges with target groups of consumers (Wallack, 1990).[5] Communication is one part of the overall strategy, and is composed of four basic components: advertising, targeted information delivery, promotion, and person-to-person exchange of information. Distribution channel strategies, or selecting appropriate intermediaries or distributors, is also considered part of the marketing mix. The relevance to the current project is that social marketing involves increasing knowledge of the audience, improving message strategies, improving message placement and media mix, and ongoing monitoring of audience response. The data collection and synthesis provided by inventory activities provide essential guidance to each of the above referenced functions.

An implication of social marketing theory is that the target audience is a prime determinant of the success of the marketing approach. In this case, the audience is the HCFA beneficiary and his or her family. Because the audience is composed predominantly of those individuals aged 65 and over, as well as some disabled individuals, some special considerations must be taken into account in planning an effective communication strategy with this audience.

Special Considerations for Elderly and Disabled Beneficiaries. As people age, they cannot see, hear, touch, taste, or smell as well as they did when they were younger (Hooyman and Kiyak, 1993).[6] While there is tremendous diversity among individuals in the rate and severity of the aging process, normal changes in sensory and cognitive functioning can dramatically affect an older person's interaction with his or her environment. Additionally, there is evidence that older people perform differently on problem-solving tasks than younger persons, with older persons being more likely to rely on heuristics or hunches (Reese and Rodeheaver, 1985). [7]

Age-related changes in one's eyes, for example, result in reduced visual acuity that can create problems, especially with reading small print or adapting to sudden changes in light level. Flattening of the shape of the cornea and thickening of the lens in the eye render older people highly susceptible to glare. Yellowing and hardening of the lens reduces sensitivity to color, making it difficult to discriminate between colors that are close together in the color spectrum, such as blue-green or red-purple (Saxon and Etten, 1994).[8] These age-related changes can have profound implications for the way information needs to be presented (especially in written form) to an older person. Another physiological change, deterioration in one's hearing, can interfere with an individual's ability to take in and process spoken information, especially when it is presented over the telephone.

Deterioration of cognitive functioning can result from a variety of causes, including depression, dementia, structural changes in the brain, and declines in auditory functioning. Older people process information differently than younger ones, especially information that is abstract and complex (Belsky, 1990).[9] Additionally, many older people are taking medications which interfere with their ability to remember or think in a formal-logical or integrative way. For example, older people tend to have difficulty with free recall of information, but are able to remember with the use of cues or mnemonics (Poon, 1985).[10]

Additionally, the process of aging entails numerous and substantial life events, including management of a chronic health condition, such as heart disease; retirement from the world of work; widowhood; and, relocation to assisted living or to a nursing home. These events and changes can be fundamentally disorienting and can challenge the older person's ability to cope with daily living. Life events that take place when one is younger generally involve social role gains or replacement, whereas events in the lives of older people tend to involve loss, such as loss of income, friends, social role, or status. One's ability to cope effectively is influenced by many factors, including socioeconomic status, health status, and access to a social network. Modification of any of these factors can improve an older person's functioning, including their ability to understand complex information. Rapid changes in the health care delivery system (such as the development of managed care plans) have increased the complexity of the Medicare program and its use. When viewed through the lens of one's other sweeping life events (many of which involve a loss), changes in the Medicare program may seem disorienting to beneficiaries.

An older person's culture and ethnic identity also shape their ability to process complex and abstract information, especially if it is presented in a language other than their own. During the second phase of the HCFA Market Research Project for Beneficiaries, we will focus on subgroups

within the elderly population, collecting data on each group's special information needs and the strategies to best present information to them.

Finally, while many of the issues that apply to the information needs of the elderly also apply to disabled beneficiaries, there are some special considerations that apply to communicating successfully with this subpopulation. First, the disability itself may present a barrier, as it may interfere with the individual's ability to access information. Second, the population of disabled beneficiaries is extremely diverse in every aspect, especially their functional abilities, so any strategy has to be multidimensional. Third, individuals who have been disabled from birth may experience life differently than individuals who have aged gradually or become disabled later in life, as they have often been totally dependent upon others for care.

These are just a few of the special considerations that should accompany any communication strategy with the elderly or disabled. Additionally, an individual's information needs change over time, both in terms of the type of information required and the optimal delivery channel. In the next section, we present evidence on the level of beneficiary knowledge and a framework for understanding the dynamic needs of beneficiaries over time.

Basic Research Questions

Research has shown that while knowledge about some aspects of health insurance coverage among the elderly population can be substantial, generally it is lower than in the population younger than age 65. Among privately insured individuals, most understand that they have coverage for hospital care and physician visits, but they tend to underestimate their coverage for mental health or substance abuse treatment and overestimate their coverage for long-term care (Garnick et al., 1993).[11] Correct knowledge of coverage of particular services tends to be associated with current experience with health problems and expected use of these health services (Cafferata, 1984).[12] Additionally, older people tend to make decisions differently than younger people, because of their increased risk of illness and changing financial status due to retirement.[13] Studies have also found that older people may be overwhelmed by both the volume and the complexity of the information regarding health care that comes their way (Sofaer et al., 1990).[14]

This Inventory Report provides insight into the two basic research questions of the Market Research Project: What information do beneficiaries need/want about the program? and What are the best ways to communicate that information to them? The first question has two primary components:

- What are effective strategies for understanding the information needs of beneficiaries?
- What are the specific information needs/wants with respect to the Medicare program?

A special problem for the analysis is that there may be a difference in the information that beneficiaries may want about the program, and the information that they may need to make effective use of the program and improve their health. For information needs/wants, we examined beneficiaries' knowledge of the basic Medicare program, managed care and supplemental

insurance, the cost and quality of care, and coverage of preventive health services. For strategies for understanding the information needs we examined a variety of techniques, including focus groups, surveys, organizational compilation and tracking of customer inquiries, techniques for partnering and decentralized information gathering, and the incorporation of information gathering and feedback into ongoing operations.

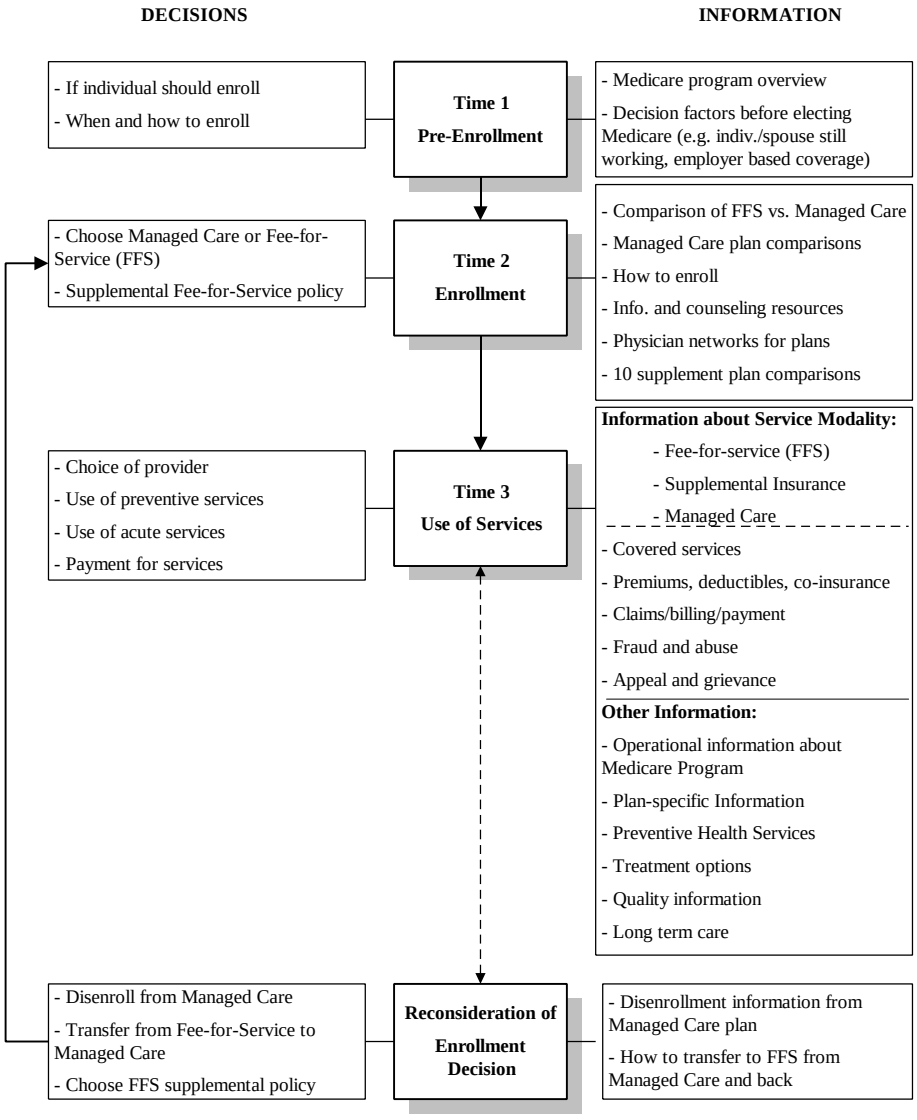
For examining effective communication strategies, the inventory focused on a range of traditional and innovative techniques with a particular emphasis on how these techniques fit with the needs and preferences of the Medicare-eligible population. Among the strategies examined were specialized printed materials, one-on-one communication techniques (e.g., toll-free telephone, provider offices, community-based organizations), small group sessions, mass media, and new technologies. The importance of the inventory lies in the fact that the findings represent the study results, expert opinions and "best practices" of those who know seniors best and the information they want and need.

Timing and Sources of Information.

It is critical to improving beneficiary information and customer support to understand that the information needs of beneficiaries change over time and vary depending upon a variety of factors, including the beneficiary's health status. For example, certain information is specifically relevant to the beneficiary being introduced to Medicare (such as "What services are covered?"), whereas other navigational information is more relevant to the beneficiary's ongoing use of the Medicare program ("How do I file an appeal?"). Information on Medicare coverage of hospital services may be relevant to an individual with acute care needs, whereas information on coverage for prescription drugs may be relevant to an individual who manages a chronic health condition, such as diabetes or asthma. Finally, information needs will vary depending upon the choices that are available in the county in which the beneficiary lives (such as whether there are HMOs in the area). In mature managed care markets, many consumers are generally knowledgeable about the features of an HMO, so the information they will want will tend to be less descriptive and more specific than the information needs of a consumer in a market with very little managed care penetration. For example, a consumer in a well developed managed care market might ask whether the physicians in an HMO have financial incentives to restrict referrals to specialists, whereas the beneficiary who is first being introduced to managed care might not understand the notion of a primary care provider acting as a gatekeeper.

Figure 1 below, the Medicare Time Line, illustrates the types of information beneficiaries are likely to need in order to make critical decisions at three different points in time: when they are about to enroll in Medicare; when they are new enrollees; and, when they have been in Medicare for a time and are using the program on an ongoing basis. Figure 1 is not intended to be an exhaustive summary of all possible types of information beneficiaries might need, but rather a way to illustrate that beneficiary information needs are determined by the type of decision they are facing, as well as their preferences.

Figure 1. The Medicare Time Line



For individuals about to enroll in Medicare, information is likely to be best used if it provides an overview of the program and is organized in large information "chunks". It should emphasize the ways the individual can obtain more in-depth information if desired, as well as provide specific information on Part B to help beneficiaries determine whether or not to take it.

The first important decision is a two-stage one: first, whether to continue to use the fee-for-service system, and if so, whether to add a supplemental plan; or to join a managed care plan, and if so, which managed care plan. Many beneficiaries do not understand the distinction between the two delivery systems. In addition to information describing the features of each (such as the primary care provider/gatekeeper or "lock-in") and how they vary, beneficiaries need to know

that they can obtain individual assistance, counseling, or further information. Many beneficiaries do not seem to understand that there is a decision to be made, and that their decision will have implications for their future health care delivery. Of course, the decision is not irrevocable--the beneficiary can switch plans, or switch from fee-for-service to managed care and back as frequently as each month. Additionally, the choice will be highly specific to where the beneficiary lives. In some states, such as West Virginia, there are no Medicare managed care plans currently available.

If the beneficiary decides to enroll in a managed care plan, comparable descriptive information about available plans is needed in order for him or her to evaluate them. The other issue that is pivotal to this decision for most beneficiaries is whether his or her doctors are in the network, as many beneficiaries have long-standing and established relationships with their physicians. An individual's health status will play an important role in this decision, so information regarding the coverage of certain specific services, such as durable medical equipment (DME) or home health care, for example, might be relevant to certain groups of beneficiaries.

Once the individual has decided upon a plan, information needs often shift from descriptive to operational, such as features of the plan and how to access them. Important issues are those surrounding covered services, deductibles and co-payments, billing, claim status, providers who take assignment, appeals and grievances, recognizing and reporting fraud and abuse, among others. In addition to information related to their coverage, at this point beneficiaries often want information about treatment options relevant to their particular situation. Additionally, they will need information that helps them to ask questions, some of which may be relevant later. Studies show that in order for information to be most effective, it should be highly personal.[15] For example, information on Medicare coverage of hospital services may be relevant to an individual with acute care needs, whereas information on coverage for prescription drugs may be relevant to an individual who manages a chronic health condition, such as diabetes or asthma. Private companies, such as Xerox, often present benefits information within the framework of each employee's personalized total compensation package.

Finally, as their life situations change, as they come to need information on long-term care options, and as the Medicare program evolves, beneficiaries may wish to reconsider the enrollment decisions they have made. Beneficiaries will need to revisit the kinds of information they received at initial enrollment, and to obtain an understanding of how the options available to them may have changed over time. Because of pre-existing conditions, they may not be able to reinstate their Medigap policy under the same terms.

Medicare beneficiaries obtain information from a variety of sources, including providers; HCFA, HCFA regional offices, or ICAs; carriers or intermediaries; social service organizations; their family and friends; their employers; and, the media. Different sources are more suited to the conveyance of different types of information. Additionally, beneficiaries trust certain sources more than others. For example, a beneficiary might trust information on HMOs obtained in a counseling session with an ICA volunteer more than the information obtained from the HMO itself. This is because the goal of the ICA volunteer is to assist the beneficiary in making his or her own

decision, regardless of the final choice of provider, whereas the goal of the HMO is to enroll the beneficiary. Therefore, an important aspect of the inventory analysis was to identify the various sources that beneficiaries use (and trust) to obtain useful information.

Finally, all communication methods are not equally effective for presenting complex information to all types or groups of beneficiaries. For example, some beneficiaries like to have all Medicare information presented at once in a comprehensive written format (like the Medicare Handbook), whereas other beneficiaries want to receive fact sheets summarizing a single topic on an ongoing basis throughout the year. Beneficiaries in the future may not want any information presented in written format, they may prefer to receive it over the Internet. Some beneficiaries may prefer to engage in one-on-one discussions with their provider in order to learn about their Medicare benefits, while others prefer public service announcements on television or radio. This Inventory Report will identify some of the situations when these methods are most effective.

Structure of the Inventory Report

The purpose of this Inventory Report is to be an operational summary of "best practices" for HCFA and its regional offices as the Agency responds to the information needs of its customers and partners. The Inventory Report is divided into two distinct products. This volume (Volume II) presents the detailed analysis of the information and data gathered from the literature review and the many interviews that were held. Another volume (Volume I) provides a short summary and synthesis of the analysis provided in this paper, and is suitable for wider distribution. This part of the Inventory Report is divided into two main components, a presentation of the findings from the literature review and the findings from the interviews and discussions with agencies, companies, organizations, and experts. Both sections are organized according to the two primary research questions:

- What information do beneficiaries want/need to know? and
- What are the best ways to communicate that information?

The literature review begins with an overview of beneficiaries' current knowledge of the program. This overview is followed by an examination of knowledge of insurance options (supplemental and managed care) and quality of care. This is followed by evidence from research on effective communication strategies and sources of information on Medicare. The literature review then concludes with a discussion of health communications and new technologies.

The Interview Findings section begins with an overview of the organizations interviewed and the interview methodology. Analysis of the information needs of beneficiaries focuses on the basic Medicare program, covered services, fee-for-service Medicare and choice of providers, supplemental policies, managed care, cost and quality of care, and preventive services. The next section discusses strategies and techniques for understanding the information needs of beneficiaries. Finally, communication strategies and techniques are presented by their purpose and the methods employed. This examination of communication strategies begins with an overview of "best practices," and concludes with a summary of our findings on specific communication tools,

including printed material, person-to-person communications, video and other mass communications, and group discussions.

LITERATURE REVIEW

Over the past few years, much has been written about consumer information needs regarding their health insurance, including the specific needs of Medicare beneficiaries. The two topics most extensively covered in the recent literature include the information needed by consumers to effectively choose a plan, as well as the information needed to assess quality of care. In this chapter, we start with a review of what is known regarding the current level of beneficiary knowledge about Medicare, then review the available research literature on the information needs related to the two primary topics. In order to illustrate the communication processes currently used with beneficiaries, we provide a discussion centering on a particular service that has generated considerable recent inquiry: influenza vaccinations.

Overview

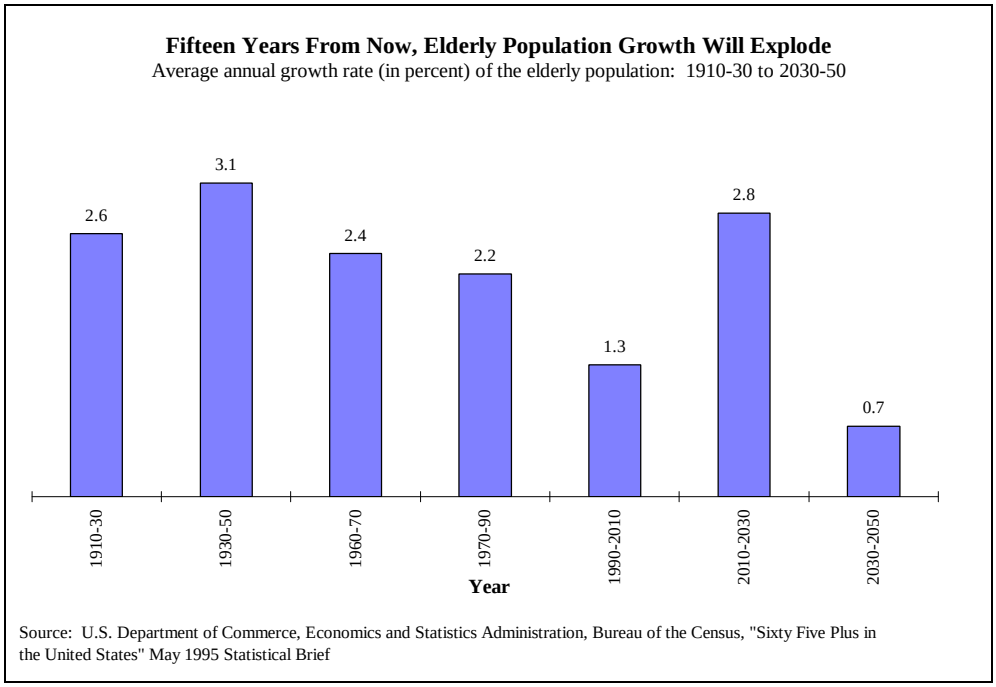
The Health Care Financing Administration (HCFA) routinely provides a range of information services to beneficiaries regarding their coverage, claims, and the program's administrative procedures. Beneficiaries, for example, receive *Your Medicare Handbook* and can access information about Medicare through toll-free telephone lines, and a variety of community-based forums (HCFA Project Customer, 1995). The goals of beneficiary communication extend beyond the provision of information, however. Successful educational campaigns can contribute to HCFA's efforts to improve access, assure adequate coverage, curb unnecessary spending, and still afford greater consumer choice.

HCFA's mission to improve beneficiary communications comes at a time of new challenges in the world of communication. The health care communication environment is changing in at least three important ways. First, Medicare beneficiaries increasingly have opportunities to make choices that affect their care. Many can, for example, elect either traditional fee-for-service Medicare or a managed care plan. After this initial decision is made, there is often a choice among competing managed care plans and, once a plan is selected, there are other important choices regarding one's primary care provider and specific health care services. New types of consumer information are being disseminated to help beneficiaries make prudent health care coverage decisions, sometimes in the form of health plan report cards that include comparative information on access to care and quality. However, there has not been a systematic review to identify what kinds of information consumers need and how the information needs to be presented to support, rather then confuse the beneficiary during the decisionmaking process (McGee et al., 1996).

A second important change is in the sheer magnitude of HCFA's communication effort. The elderly population is expected to double in the next 50 years, as the baby-boom cohort ages into retirement (U.S. Census Bureau, 1995). Consequently, HCFA will have to deliver its message to a much larger audience. Careful attention to the content of messages and how to deliver the messages will be necessary as the makeup of the elderly population changes. As "baby boomers" begin to retire between the years of 2010 and 2030, there will be a sizeable group of "young old" in the elderly population, characterized by considerable diversity in terms of race and ethnicity. The "oldest old"--those aged 85 and over--which is the most rapidly growing elderly age group

and which will continue to grow. In 50 years, the "oldest-old" will represent 5 percent of all Americans, and nearly one-quarter of the elderly. In 1994, one in ten elderly were a race other than white. By 2050, this proportion should rise to one in five. Similarly, the proportion of elderly who are Hispanic is expected to climb from four to sixteen percent over the same period (U.S. Census Bureau, 1995). HCFA will have the challenge of developing communication strategies that are appropriate for the newly retired, as well as strategies for the oldest cohort, who may increasingly have functional limitations, unique cultural attributes, and speak languages other than English (Waite, 1996).

Figure 2. Growth in the Elderly Population, 1910-30 to 2030-50



The third important change is the development of new communication technologies. On the horizon are increasingly user-friendly computer software, more sophisticated applications of the Internet, sophisticated telephone systems, and interactive television. These technologies have allowed new models of communicating with particular populations, such as members of an HMO or persons with a specific chronic condition. Finding applications for these technologies in providing Medicare beneficiaries with new kinds of information is not difficult. More challenging is creating the appropriate infrastructure to allow the many groups participating in the educational process access to these technologies. A further challenge will be to make these formats available to the elderly, and to provide training so that they can be effectively used.

The extent to which Medicare beneficiaries understand their health insurance coverage and how Medicare works, and how best to provide Medicare beneficiaries with the information they need to make informed choices, are the topics of this literature review. While the focus of this review is on Medicare beneficiaries, there are a number of ongoing research activities aimed at learning

more about what health care consumers know about health care, what information they would like to have when making decisions about health care coverage, and how that information should be presented. Research conducted within the general population, but relevant to the Medicare population is sometimes included in this review. Appendix I in this volume includes a description of the literature search methodology used for this review.

Information that Medicare Beneficiaries Want and Need

This section of the literature review provides an overview of what Medicare beneficiaries know about the Medicare program, the various insurance options (such as supplemental insurance and managed care), and then turns to the literature on what beneficiaries want or need to know about the quality of health care.

Knowledge of the Medicare Program

In order to determine what beneficiary information needs are, it is important to first establish their level of knowledge about Medicare and health insurance in general. Several surveys have recently been conducted, both of Medicare beneficiaries and of the general population, and are reported in the literature. The Department of Health and Human Services (DHHS), Office of Inspector General (OIG) fielded a number of surveys of Medicare beneficiaries over the last few years on a variety of topics, such as satisfaction with Medicare Risk HMOs or satisfaction with home health services. Additionally, in 1995 Louis Harris and Associates fielded a survey of the general population's level of knowledge regarding managed care.

One-in-five (21 percent) of Medicare beneficiaries reported in 1994 that the Medicare program is "not understandable" when they were asked as part of one recent OIG survey (DHHS, OIG, June 1995).[16] This finding is important because more than a basic understanding of Medicare coverage is essential as beneficiaries are increasingly faced with two-stage choices, such as the initial choice between fee-for-service Medicare or a Medicare HMO, and then choices among a range of supplemental insurance policies and managed care plans. A more in-depth understanding of Medicare is essential.

Medicare beneficiaries are not alone in their confusion regarding their health insurance coverage. Health insurance has become quite complex and many consumers, both young and old, are unfamiliar with some of the basic concepts that underlie newer insurance products and health care delivery systems. According to the 1995 Louis Harris survey, for example, most Americans (55 percent) have never heard of, or do not know the meaning of "managed care" and nearly one-third (31 percent) do not know what "HMO or Health Maintenance Organization" means (Louis Harris and Associates, 1995).

Despite efforts on the part of HCFA and others to inform beneficiaries of the essential elements of their coverage, there appear to be gaps in understanding basic information including the services for which Medicare pays. Nearly one-quarter (23 percent) of Medicare beneficiaries who had been hospitalized, for example, did not understand for which hospital charges Medicare had paid, and among those who had received home health services, nearly as many (21 percent) did not

understand which home health services Medicare covered. Furthermore, the majority of beneficiaries (64 percent) are unaware that Medicare pays for a second opinion when surgery has been recommended (Table 1) (DHHS, OIG, June 1995).

Similarly, there appear to be gaps in understanding certain aspects of how the Medicare program operates. For example, nearly one-third (31 percent) of beneficiaries are unaware that they could appeal or request a review of decisions made on their Medicare claims (DHHS, OIG, June 1995).

Table 1. The Medicare Beneficiary Satisfaction Survey

Communication-Related Questions	1994 (% saying yes)
Program is understandable	79%
Get information when needed*	75%
Recall receiving *Your Medicare Handbook*	76%
Wording easy to understand	84%
Covers enough information	87%
Lettering large enough to read	93%
Claims paid quickly enough	73%
Best method for receiving new information	
Pamphlet or handbook through mail	39%
New *Your Medicare Handbook*	37%
Notice with Social Security check	17%
Television or radio announcement	5%
Other	2%
Knew second opinion paid by Medicare	36%
Ever heard about 'participating' doctors program	82%
Number of beneficiaries surveyed	1279
Response rate	78%

Source: DHHS, Office of Inspector General, Medicare Beneficiary Satisfaction: 1994

Despite some confusion over some aspects of Medicare coverage, awareness of certain components of the Medicare program appears to be relatively high. The Participating Physician and Supplier Program implemented by HCFA in 1984 offers incentives for physicians to accept assignment for Medicare claims which, in effect, means that they agree to accept the "Medicare-allowed charge" as payment-in-full for an office visit (80 percent of which is paid by Medicare after the deductible is met with a beneficiary liability of 20 percent). The Medicare program provides annual directories of participating physicians, and beneficiaries can contact Medicare carriers or Social Security offices to get information from the directories. In 1994, as many as 82 percent of beneficiaries were familiar with the program, and 71 percent used these physicians (OIG, 1995). However, a sizable portion of beneficiaries (21 percent) do not know that they can call the insurance company that processes their claims to get the names of doctors who are

participating doctors and relatively few (6 percent) beneficiaries had contacted their carrier to obtain this information.

Medicare beneficiaries are less familiar with a program implemented later than the "Participating Doctor" program. Starting in 1990, the Medicare program instituted a program to help qualified low-income Medicare beneficiaries with some of their out-of-pocket health care costs (i.e., deductibles and coinsurance payments related to their Part B Medicare). Despite efforts to disseminate information about the program through mass mailings, public service announcements, and media coverage, fewer than one-in-ten (7 percent) of those eligible for the program had ever heard of it when asked as part of a survey in 1993 (Neuman et al., 1995). Furthermore, a substantial number of beneficiaries were actually enrolled in the program and did not know it. While participation in the program was low, those beneficiaries who do participate tend to be those most in need of the program (i.e., those with the lowest incomes and highest health care utilization). Reasons why eligible non-enrollees said they were not participating in the program included that they did not need the program (33 percent), they thought that they did not qualify for it (27 percent), or did not know about it (16 percent) (Neuman et al., 1995). It seems that if an individual has participated in the decision of whether to join an HMO, he or she has acquired knowledge of the systems.

In an earlier study of Medicare knowledge using 1977 data, neither education, health status, nor income was strongly associated with general Medicare knowledge or knowledge of coverage of particular services. Overall knowledge was lowest among the very old, non-whites, and persons without supplemental insurance. Those with current health problems and higher users of services tended to be more aware of what Medicare did and did not cover (Cafferata, 1984). Not surprisingly, beneficiaries who had purchased supplemental coverage to their Medicare plan had higher levels of Medicare knowledge (McCall et al., 1986). An earlier study of the characteristics of those unfamiliar with the program concluded that those beneficiaries that were black, had less than a college-level education, and were without a regular source of care were the least informed about the program (PPRC, 1989). However, the more recent evidence suggests that Medicare beneficiaries in HMOs tend to know more about their coverage than beneficiaries with fee-for-service plans with supplements, perhaps because the benefit structure of HMOs is simpler to understand (Sofaer et al., 1992).

One study suggests that even though the elderly use the health care system more than younger persons, they are less likely to behave as critical consumers because they are less likely than younger health care consumers to seek information, to exercise independent judgment, to be sensitive to cost, and to be knowledgeable about the health care system. Among the Medicare beneficiaries in this study, those with more experience with the health care system appeared to be more knowledgeable. Women and those with higher educational attainment appeared to be more likely than men or those with less education to seek health-related information (Hibbard and Weeks, 1987).

Although a sizable portion of the Medicare population is not confident of their knowledge of the Medicare program, and there appear to be significant gaps in understanding some basic elements

of the Medicare program, similar results are found among the general population. Indeed, some evidence suggests fairly large gaps in the general population's understanding of their health coverage. Although privately insured people tend to understand the basic elements of their insurance plans, they underestimate their coverage for some services (e.g., mental health, substance abuse and prescription drug benefits) and overestimate others (e.g., long-term care benefits) (Garnick et al., 1993).

Knowledge of Insurance Options: Supplemental Medigap Insurance and Managed Care

Medicare beneficiaries must make several important decisions about their health insurance. First, they need to decide whether or not to consider HMO membership as an alternative to fee-for-service Medicare and supplemental Medigap coverage. If they decide to consider managed care, they may well have to judge the relative merits of multiple plans with different structures and financing (e.g., IPA versus staff or group model HMOs; cost versus risk-HMO contract, point of service options). On the other hand, if they decide to stay within the fee-for-service system, they may choose from several types of supplemental Medigap plans (*Health Pages*, 1996). Additionally, many beneficiaries need information on long-term care, and must negotiate a separate and complex system of options for care. Because most seniors are currently in the fee-for-service care system and must make decisions about supplemental or Medigap plans, the literature on options for supplemental insurance is discussed first. Then a review is provided of what is known about beneficiaries' decisionmaking processes regarding managed care.

Most Medicare beneficiaries (over 75 percent) have some form of coverage to supplement fee-for-service Medicare. The coverage may be an individually purchased Medigap policy, an employer-based policy, or coverage through Medicaid or other programs. Individually purchased Medigap policies must conform to models developed by the National Association of Insurance Commissioners and HCFA. Even though plans are standardized, Medicare beneficiaries still face a choice among as many as 10 types of plans, each of which may be offered by several insurance companies. Under these circumstances, plans and plan premium information is often difficult to compare (Lubalin et al., 1994). Further confusion arises with the availability of long-term care insurance policies. Relatively few Medicare beneficiaries have such private long-term care coverage, and which long-term care services are covered by Medicare, Medigap policies, and Medicaid is a general source of confusion (Rice, 1987). So-called "extra cash" and "dread disease" plans add further to the complexity of the supplemental insurance market place.

Prior to the standardization of supplemental insurance policies, there were numerous examples of the elderly falling prey to insurance brokers and purchasing multiple, duplicative, and at times, poor insurance products. Fears were that the least knowledgeable beneficiaries would be taken advantage of. Some recent evidence, however, suggests that the purchase of more than one source of supplemental insurance is not related to consumer ignorance or vulnerability. Instead, beneficiaries with multiple policies tend to be younger, more highly educated, and wealthier (Short and Vistness, 1992). Some estimates are that as many as 13 percent of Medicare beneficiaries in 1995 had unneeded multiple sources of supplemental insurance (GAO, 1995). Other evidence suggests that those who are more knowledgeable of Medicare's benefits (and

limitations) have supplemental coverage policies and among those that have such coverage, those who are better off socioeconomically tend to make better policy choices (Rice, McCall, and Boismier, 1991).

Medicare beneficiaries increasingly understand they have choices, and are beginning to view managed care plans as an alternative to traditional fee-for-service care. As of November 1, 1996, 4.6 million Medicare beneficiaries were enrolled in managed care plans offered by 333 organizations. Of these, 4.1 million beneficiaries were enrolled in 238 risk-contract HMOs (HCFA OMC, November 1996). While this number represents only about 12 percent of all beneficiaries, the number is expected to climb to 25 percent by 2002 in response to cost-cutting efforts within the Medicare program and aggressive marketing of managed care plans offering beneficiaries extra benefits, such as vision and dental care (State Health Watch, 1996). Medicare enrollment in managed care has lagged behind the private sector and so now represents the "last frontier" of untapped markets for the managed care industry (Armstead et al., 1995).

Currently there are states, however, in which beneficiaries do not have access to a Medicare HMO that serves their ZIP code. These states are mainly in the Midwest and the South. Some analysts estimate that only 74 percent of beneficiaries have access to a Medicare HMO (Medicine and Health, October, 1996). Currently, overall managed care enrollment is concentrated in six States: California, Florida, Pennsylvania, Arizona, New York, and Massachusetts (State Health Watch, September 1996). As health plans consolidate in some of these markets, Medicare enrollment is concentrated into certain plans. For example, as many as one-quarter of the country's Medicare HMO enrollees may soon be enrolled in PacifiCare, which recently purchased FHP, another major Medicare provider in the area (*Business and Health*, Sept. 1996).

Beneficiaries entering Medicare from employer-based health plans will increasingly have direct experience, or at least familiarity with managed care concepts, as most large companies are encouraging retirees to join managed care plans. As many as 60 percent of early retirees with employer-sponsored coverage are now in managed care plans, including HMOs, Preferred Provider Organizations (PPOs), and Point of Service (POS) plans. Many of those electing PPO coverage are being transitioned into HMOs (McCarthy, 1996). As managed care becomes more widely available, Medicare beneficiaries will need to understand the basic concepts underlying managed care, in order to judge its impact on their cost and quality of care. In all likelihood, beneficiaries will soon be faced with additional variations on the managed care theme, such as PPOs, POS and provider-sponsored networks. The extent to which beneficiaries understand these emerging delivery models is not well understood.

According to focus groups held in 1995, relatively few beneficiaries and pre-beneficiaries are aware of how managed care functions under Medicare, and consumers outside of the areas where HMOs have high penetration and established reputations are particularly uninformed. Attitudes toward managed care among Medicare beneficiaries vary significantly, and are determined by the interaction between word-of-mouth and the level of HMO penetration and exposure in the area. In southern Florida, there is high HMO penetration, yet beneficiaries' attitudes tend to be negative because of the power of word-of-mouth conveyance of bad experiences and fraud. In other areas

where beneficiaries have had more positive experiences with HMOs, attitudes are more favorable in the high-penetration areas. Here, the positive experience of HMO plan members tends to counterbalance any negative or stereotypical perceptions of managed care (e.g., limited choice of doctors, long waits for appointments). In other markets with very little HMO penetration, beneficiary attitudes about managed care are very positive. (Frederick/Schneiders, Inc., 1995).

HCFA is sponsoring research to better understand how to impart health insurance information to beneficiaries as part of its initiative, "Information Needs for Consumer Choice." Researchers are testing print and videotaped materials which both provide information and lead beneficiaries through the health plan decisionmaking process (Garfinkel, 1996). Several state-level initiatives are also underway to improve beneficiaries' awareness of their health care choices. In Rhode Island, for example, a non-profit consumer advocacy organization, Aging 2000, is working with Medicare HMOs, Medigap insurance companies, HCFA, and the National Committee on Quality Assurance (NCQA) to inform seniors about new coverage options and the quality of services provided by local health plans and providers. The group sponsors "Understanding Managed Care" workshops and produces a consumer publication "It's Your Choice." which offers a comparison of the costs, coverage, and benefits of available plans (Zesk, 1996). In New York, the Medicare Rights Center has issued a list of questions for consumers to ask before choosing an HMO (Figure 3). These questions help structure the beneficiary's thinking, as many beneficiaries report not even knowing the questions they should be asking.

Health plans themselves, through their marketing efforts, are an important source of plan information. HCFA has established rules to help ensure that beneficiaries receive clear, complete information about the options available to them through the Medicare HMO-risk program. These rules affect a broad range of practices including the plan's use of language in describing its products, marketing solicitation practices, and enrollment and disenrollment procedures. National HCFA marketing guidelines are being developed in cooperation with the American Association of Health Plans (AAHP) to establish a single set of rules for HCFA regional offices (Shapiro Snyder, Healthplan, September/October, 1996).

The two issues that are of primary importance to beneficiaries in making the decision to join an HMO are: 1) whether the beneficiary's physicians belong to the HMO network, and 2) the financial benefits of HMO participation. Available evidence suggests that whether a beneficiary's own physician is a participant in a managed care plan is the most important determinant of electing that managed care plan. More broadly, Medicare beneficiaries report that "choice of physician" is their number one concern when considering a plan (Frederick/Schneiders, Inc., 1995; HCFA, Study of Information Needs, 1996). Loyalty to one's provider appears to be very high among Medicare beneficiaries. In one study, for example, nearly 60 percent of members of a health plan left the plan to follow providers who had left the plan and joined another (Sofaer and Hurwicz, 1993). While earlier studies found that many Medicare beneficiaries will sever their

Figure 3. Questions to Ask Before Choosing an HMO

Doctors, Hospitals and Other Health Care Providers:

- Who are the primary care physicians available to you?
- Are they accepting new patients?
- Does the health plan control the care they deliver and the specialty referrals they make?
- Does the health plan provide incentives for doctors to provide less care or impose penalties on doctors who do?
- Not follow their treatment guidelines?
- Who are the specialists, hospitals, home health agencies and nursing facilities to which you will have access?
- What will your rights be if your doctor leaves the HMO network?
- Does the plan permit your doctors to notify you if they leave the network?

Health Care Access:

- How long, on average, will you wait for an appointment with your primary care physician or specialist?
- If you travel and require health care services, under what circumstances will the health plan pay for your care?

Health Care Quality:

- If you have or develop a complex illness, will you be required to visit your primary care physician each time before you can see a specialist?
- If you want a particular type of treatment or a particular drug for your illness, what right will you have to receive that treatment or that drug?

Enrollee Satisfaction:

- What is the satisfaction of health plan enrollees generally and, specifically, of enrollees with complex illnesses?
- What is the disenrollment rate?

Benefits:

- What benefits are available and under what circumstances does the plan cover these benefits?
- If the HMO does not require doctors to seek prior authorization before delivering a service or making a referral, will the manner in which the HMO pays the doctor provide an incentive for the doctor to deny or reduce services?
- Does the delivery of costly benefits cost your doctor money?
- How much will you pay out-of-pocket to receive these benefits?
- If the plan does not provide these benefits, how much will you pay out-of-plan for them?

Patients with Chronic or Complex Illnesses:

- Will the HMO provide protocols, treatment guidelines, or lists of approved drugs related to your illness?
- Can you appoint a specialist to act as your primary care physician?
- Does the HMO have special programs for people with your illness?
- Does the HMO know how many people with your illness are enrolled?

Source: Diane Archer, Executive Director of the Medicare Rights Center, Plenary Speaker, "Value and Choice: Providing Consumers with Information on the Quality of Health Care," Sponsored by the Henry J. Kaiser Family Foundation and the Agency for Health Care Policy and Research, October 29-30, 1996.

relationship with a provider for more comprehensive coverage and the lower costs associated with managed care plans (Ward and Bryant, 1986), the most recent research shows that consumers are

unwilling to change physicians or consider another plan, even when given the option of a lower cost provider (Hibbard and Weeks, 1989; Rice et al., 1992).

In an attempt to convey the potential financial consequences of health plan choice in a concrete way, one group of investigators presented Medicare beneficiaries with the costs associated with the care for 13 illness episodes which varied in severity. Out-of-pocket costs associated with each illness episode were calculated for both fee-for-service and managed care plans. While the financial implications of plan choice became very clear to study participants, comparative plan information on quality of care was not available, however, to provide the more comprehensive information that is often needed for the decisionmaking process. Study subjects exposed to this illness episode educational approach were no more likely than those with traditional insurance education to purchase HMO coverage, or new or different Medicare supplementary policies, but were more likely to drop duplicative coverage and spend less on premiums (Sofaer et al., 1992; Sofaer et al., 1990; Sofaer et al., 1989).

Medicare beneficiaries who join HMOs have tended to be healthier than those who remain in fee-for-service plans (Lichtenstein et al., 1992). Some evidence, however, suggests that sick beneficiaries who are well informed of their Medicare coverage and plan options are more likely to either purchase a Medigap policy or to enroll in an HMO than those who are well-informed, yet healthy (Davidson et al., 1992). Conversely, among those who are not well informed of their Medicare coverage, the healthy are more likely than the sick to enroll in an HMO. These findings, if confirmed by other research, imply that increased beneficiary knowledge may reverse the current favorable selection into HMO plans.

Evidence on What Medicare Beneficiaries Want/Need to Know About Quality

As managed care markets mature, some speculate that quality will replace cost as the primary factor in consumer and purchaser decisionmaking (Armstead, 1995). A number of initiatives are underway to develop report cards that include important cost and quality indicators to facilitate plan comparisons. The National Committee on Quality Assurance (NCQA), for example, has developed a reporting system that includes clinical indicators such as the extent to which a health plan provides routine immunizations, as well as information on consumer satisfaction with plans (NCQA, 1996). The relevance of these indicators to consumers is not clear at this time. Some recent general population surveys reveal that consumers may not yet be sophisticated enough to find these measures useful. Instead, most consumers value information on providers and provider choice.

In a recent survey of the general population sponsored by the Agency for Health Care Policy and Research and the Kaiser Family Foundation, many respondents felt that quality was most important to them; more important than cost, choice of physician, and range of benefits. However, among those persons who had seen information comparing quality, relatively few said that they had used it in their own decisionmaking (Kaiser/AHCPR, 1996). According to another survey of the general population, a large majority of consumers (84 percent) are interested in using report cards to compare different health plans when choosing a health plan (Louis Harris

and Associates, 1995). The five plan attributes considered most important by consumers in rating a health plan were:

- The quality of doctors in the plan;
- The courtesy and manner of the doctor and other staff;
- The ability to choose your own doctor;
- The ability to go to specialists of your choice; and
- The ability to go to the hospital of your choice.

Also according to the Harris survey, the top four areas where consumers feel that they need more information to make good health care decisions include:

- Information about specialists;
- Medical information such as information on certain illnesses and conditions;
- Quality of doctors covered by health plans; and
- The range of services that are covered by health plans.

In another general population survey, consumers were asked to rate the most important of five categories of report card information in choosing their health plan (Raymond, 1995). Choice of doctors was ranked as most important (49 percent) followed by benefits information (20 percent) and results of patient satisfaction surveys (13 percent). Relatively few thought that information on access or standardized measures of quality were most important (10 and 9 percent, respectively). When asked to identify the most important quality measures, twice as many respondents were interested in information on the success of medical procedures than the usually reported process measures such as immunization and screening rates.

Findings from focus groups of Medicare beneficiaries indicate that they, like members of the general population, tend to concentrate on physician-related factors, such as physician choice, communication, and technical quality (RTI, 1995; Lohr et al., 1991). Focus groups that included those with chronic illness and retirees indicated that they thought of competent doctors and high levels of accessibility as representing "quality". Specific physician qualities mentioned were good communication skills, the ability to listen and trust what the patient tells them, and the ability to make excellent referrals in times of crisis (NCQA, 1994).

A number of quality measures felt to be potentially helpful in making health plan choices were tested by NCQA in focus groups among Medicare beneficiaries and with family members who help make health care coverage decisions for Medicare beneficiaries. The measures that were evaluated included flu vaccination rates, cholesterol screening, patient satisfaction with pain management, waiting time for appointments, post-hospital discharge functional status of the frail elderly, and plans' awareness of members' advance directives. Focus group members had trouble understanding how some of the measures could be used to judge plans because they did not see how the actions of health plans could have an impact on quality measures like immunization rates. More familiar measures, such as those from patient surveys and access measures (e.g., satisfaction

with pain management, waiting time for appointment) were better understood. Medicare beneficiaries were more interested in measures of how well HMOs took care of people who were sick than in preventive measures. Participants strongly favored the collection, checking or verification of data by a neutral third party and were skeptical of data reported directly by health plans. Some were also distrustful of government sources (McGee et al, 1996; Sofaer, 1996).

In the late 1980s and early 1990s, HCFA published selected quality indicators for consumers including hospital-specific mortality rates, and the results of nursing home inspections. Relatively few beneficiaries knew about the availability of the mortality data (7 percent in 1991) and only a fraction of these had ever used the information. Significantly more seniors (25 percent) had heard of the nursing home reports, but again, few had ever used to information (DHHS, OIG, 1989, 1991).

HCFA is supporting the development of performance indicators by NCQA and the Foundation for Accountability (FACCT). Some Peer Review Organizations (PROs) have begun to use such quality indicators for external reviews of care provided to Medicare beneficiaries (Armstead et al., 1995). As part of its Health Care Quality Improvement Program, HCFA is developing performance indicator data for nursing homes to facilitate consumer comparison of facilities. These data will likely not be available for beneficiary use for several years. More immediately, HCFA is planning a beneficiary satisfaction survey designed to collect data from Medicare beneficiaries in HMOs and plans are to provide beneficiaries with information to help them choose providers (Gaus, 1996). In 1997, HCFA plans to provide comparative data about HMO benefits, premiums, and cost-sharing requirements on the Internet. When available, results of plan member satisfaction surveys and outcome indicators will be added to the side-by-side comparison charts (GAO, 1996). The GAO has reviewed HCFA's beneficiary education plans and suggests that information that HCFA already collects could be useful to beneficiaries in discriminating among HMOs (e.g., Medicare HMO enrollment and disenrollment rates, Medicare appeals, beneficiary complaints, plan financial condition) (GAO, 1996).

Some states are involved in the collection of quality data for consumers. Minnesota, the state that has the most experience, has conducted statewide surveys of enrollees in all types of health plans, private and public, and reported the ratings to consumers. Enrollees reported their overall satisfaction with their plan and rated the plans' choice of doctors, benefits and coverage, continuity of care, customer services, access to care, and other aspects of medical services. Survey results have been published as an insert in newspapers throughout the state, and the report is made available in public libraries and through the Internet. This effort is being evaluated through focus groups, structured interviews with participating health plans' medical directors, surveys of employers, and state employees (Minnesota Health Data Institute, 1996; Cunningham, 1996; Medical Outcomes Trust SourcePages, 1996).

Evidence on the Most Effective Communication Strategies to Inform Medicare Beneficiaries

Just as we began the section on information needs by presenting the level of beneficiary knowledge of various aspects of Medicare, we begin this section by describing the range of activities HCFA currently uses to provide information to beneficiaries. The review is not exhaustive of all HCFA communications activities, but does convey the range of activities undertaken. Medicare beneficiaries are currently using a variety of sources of Medicare information including *Your Medicare Handbook*, the HCFA and SSA toll-free telephone numbers, and personnel within doctors offices. While HCFA is using a variety of methods to provide information to Medicare beneficiaries (see Figure 4), there is little evidence with which to rate the relative merits of one method versus the other method. In a case study of 24 organizations that are providing information to help consumers make health care purchasing decisions, print materials are the most common medium used to convey information, but other mechanisms also in use include seminars, telephone hotlines, individual counseling, videos, and interactive software (McCormack et al., 1996).

Figure 4. Examples of HCFA's Customer Service Activities

Television-Public service announcements (PSAs) for television airing have been developed by state health insurance counseling and assistance programs (HICAP), insurers, HCFA's regional offices, and others on the Medicare program and on specific topics, such as the QMB program, physician billing, Medigap, HMOs, and Medicare's influenza immunization benefit. PSAs in both English and Spanish advertise some local health insurance counseling programs.

Radio--A few consumer radio shows on Medicare are on the air in some areas. Some allow for call-in questions and are targeted to certain minority groups (e.g., the Chinese communities in New York City and San Francisco). Representatives of HCFA's regional offices in some areas are available to answer questions. Numerous PSAs have also been developed for the radio, including ones advertising local health insurance counseling programs, promoting mammography screening and flu shots, and discussing Medicare fraud and abuse.

Videocassette tapes--"Medicare 101" and "How Medicare Works for You" are among the videotapes that have been developed for distribution to SSA offices, senior citizen centers, and libraries. Some have subtitles and so can be used by those with hearing impairments. Videos covering specific topics are also available (e.g., fraud and abuse, coverage of respiratory therapy for acute and skilled nursing facilities, Medicare myths, interpreting the EOMB).

Audiocassette tapes-- *Your Medicare Handbook* is now available in English and soon will be available in Spanish for beneficiaries and advocacy groups in Illinois and Michigan.

Figure 4 (Continued)

Print media--HCFA's regional offices routinely issue a beneficiary newsletter and press releases on Medicare issues and many HICAP programs advertise their services in magazines and newspapers, sometimes targeting Asian, Hispanic, and African American seniors. Regular Medicare-related columns are written by some regional offices and appear in local newspapers. One carrier writes a monthly beneficiary newsletter which is distributed to senior citizens centers and advocacy groups. To facilitate rapid communications, one regional office has subscribed to a press delivery service that releases HCFA's message via computer modem. Among the informational brochures available to Medicare beneficiaries are those on home health benefits, how to appeal Medicare decisions, HMOs, supplemental health insurance, and hospice care. Many states publish Medigap comparison guides.

Electronic message boards and billboards--Rotating messages in both English and Spanish were run on an electronic message board onboard the Dallas Area Rapid Transit system encouraging adult children to tell their parents to get a flu shot.

Individual written communications--All HCFA offices, Medicare carriers and intermediaries, and ICAs provide service through personal correspondence. There are some efforts to standardize language to make correspondence clear, concise, accurate, and appropriate in tone. Spanish translations are available, and efforts are also underway in at least one area to produce a Spanish EOMB.

Telephone--All HCFA offices, Medicare carriers and intermediaries, and ICA programs provide customer telephone service. All carriers and many ICA programs offer a toll free number. Many carriers provide TDD service. There are now numerous sources of Medicare information by telephone, and there are some attempts to provide a "one-stop-shopping" approach by linking providers of information (e.g., HCFA and SSA).

Computer/Internet--HCFA's "home page" for the World Wide Web is being expanded and on-line access to managed care information is under development. HCFA contracts with the SPRY foundation to maintain a Seniors Forum on CompuServe. Some regional carriers have put Medicare program policies on-line and have developed a user friendly "Windows" interface.

Source: Project Customer: A Listing of HCFA Customer Service, September 1995

While a variety of communication strategies are in use, there is little information with which to judge the relative effectiveness of educational strategies to improve Medicare beneficiaries' understanding of Medicare and their ability to make informed choices (Davidson, 1988). In the past few years, HCFA has begun to focus-group test materials with beneficiaries before publishing them. Pretesting the message is a very important step in developing materials, and while HCFA has begun to do this, more needs to be done. The difficulties of communicating programmatic information to Medicare beneficiaries is illustrated by the attempts to educate consumers of changes to the program following enactment of the Catastrophic Health Care Coverage Act (CHCCA) in 1988. The legislation was repealed in 1990, but HCFA did launch a major education program to inform beneficiaries of changes in 1988. HCFA conducted two mass mailings to inform beneficiaries of changes to their basic coverage and new benefits, such as hospice care and prescription drug coverage. First, a twelve-page pamphlet highlighting program changes was sent in September of 1988, and then in December, each beneficiary was mailed a new Medicare

Handbook which also summarized program changes. Despite these efforts and considerable media attention that accompanied the legislation, the majority of beneficiaries did not understand the implications of the new legislation. No more than one-half of respondents to the June, 1989 OIG survey reported knowing about any of the five major programmatic changes (DHHS, OIG, 1989).

The difficulties of communicating complex information about health insurance coverage are not confined to the elderly population. In one study, an attempt to educate a previously uninsured population about new subsidized health insurance was largely unsuccessful, even though a number of communication methods were employed (Garnick et al, 1993). As part of this study, five participating plans (all were either HMOs or provider networks) launched an educational effort that included providing new enrollees with information through a variety of mediums, including: detailed enrollment contracts; brochures; question and answer documents in English and Spanish; videotapes; and individual in-person meetings (at one plan, attendance at an educational seminar was required).

Despite these educational efforts, the majority of new enrollees did not understand very basic information regarding their coverage when asked one year after enrollment. Study subjects were asked if their plan paid for an annual physical exam, whether their plan paid for emergency care when they were outside the area, and whether their plan limited their choice of hospitals. Overall, fewer than one-third of enrollees could answer all three questions correctly. Possible explanations for the poor level of knowledge include:

- Lists of services included in a plan description do not adequately convey what services are not covered;
- People may only be interested in knowing what their coverage includes when they need care;
- People with multiple plans may not realize the extent to which their coverage is merely duplicative, and think they are covered for certain services because they have multiple plans; and
- People may not know much about services they do not anticipate using.

Preventive Services: Influenza Vaccination

An example which illustrates a specific communication effort regarding a newly-covered preventive health service is the influenza vaccination. Medicare beneficiaries' use of preventive health services falls short of Healthy People 2000 goals established by the Public Health Service. For example, while the identified target rate is at least 60 percent, fewer than 40 percent of non-institutionalized Medicare beneficiaries currently use their influenza immunization benefit (Vladeck, 1994). Immunization rates are particularly low within certain subpopulations within the Medicare program (e.g., racial and ethnic minorities, older women, and rural residents). HCFA has recently launched a Consumer Information Strategy to improve these rates. With an initial focus on preventive services, HCFA hopes to help beneficiaries stay healthy by encouraging them to use effective preventive services such as the influenza vaccine. The literature on Medicare

beneficiaries' use of the influenza vaccine is reviewed here to learn more about the communication strategies that work best to increase the use of this Medicare-covered prevention benefit.

Influenza has the potential to cause serious illness and premature death among the elderly, especially those with chronic conditions such as lung or heart disease, diabetes, and cancer. Recommendations are that the elderly receive an influenza vaccine annually in the fall (Nichol, 1993). Since 1993, beneficiaries have been able to obtain influenza vaccinations without a co-payment, even if they have not yet reached their deductible limit (MMWR, 1994; McBean et al., 1991). Because these vaccinations are fully covered by Medicare, cost is no longer a barrier to use. However, a 1995 survey of Medicare beneficiaries suggests that as many as one-quarter do not know that Medicare pays for flu shots (OIG, 1996).

Barriers to receiving vaccinations reported by beneficiaries include: their lacking information about the Medicare benefit; fear of adverse effects of the vaccine; lack of confidence in the efficacy of the vaccine; feelings that obtaining the shot is inconvenient; or having received little encouragement from health care providers to receive the vaccine (Ives et al., 1994; Nichol, 1992; Ohmit and Monto, 1995). In some areas, Medicare's reimbursement for vaccine administration is close to the cost of the vaccine, giving providers little financial incentive to provide the vaccine (McBean, 1991). Other factors that may contribute to low adult vaccination rates are that no comprehensive vaccine delivery systems are available, there are no statutory requirements for vaccination for adults as there are for children, vaccination schedules may be complicated (e.g., they may vary by age or health condition), opportunities to vaccinate adults are frequently missed during contacts with health-care providers, and vaccination programs have not been established in settings where high-risk adults congregate (MMWR, 1991).

Community-based interventions, including educational campaigns targeted to both beneficiaries and providers, have achieved some success in improving vaccination rates. A number of HCFA/CDC sponsored Medicare Influenza Vaccination Demonstration projects conducted between 1988 to 1992 offered complete coverage for vaccines, together with community-wide educational programs aimed both at beneficiaries and providers. This approach demonstrated that coverage and education can improve immunization rates. Because these demonstration projects were conducted to test the cost-effectiveness of providing Medicare coverage for the influenza vaccine, it is difficult to assess the relative contribution of the new communication strategies. Descriptions of selected demonstration projects are in Appendix II of this volume. Nevertheless, valuable lessons have been learned from these demonstrations sites and include the following:

- Reaching the Healthy People 2000 goals of vaccinating at least 60 percent of community-dwelling Medicare beneficiaries is achievable, but appears to require both public media campaigns and intensive educational campaigns targeted to individual beneficiaries and their providers (MMWR, 1993).
- Incorporating influenza vaccination into a comprehensive prevention program can be a very successful strategy to boost immunization rates (Ives et al., 1994).

- Making vaccines accessible in non-medical settings frequented by the elderly, like shopping malls, appears to be a successful intervention strategy (MMWR, 1991).
- Financial incentives for physicians proved to be very successful in improving vaccination rates in one of the demonstration sites (Bennett et al., 1994). Physician participation in some demonstration projects was shown to be motivated chiefly by economic considerations (i.e., receipt of free vaccine and reimbursement for services) (Etkind, 1996).
- When given the option, beneficiaries appear to prefer immunization services through private physician's offices rather than through a local hospital (Ives et al., 1994).

Studies of various low-cost methods of communicating with beneficiaries to remind them of the need to vaccinate show that significant gains in immunization rates (on the order of 10 to 30 percentage points) can be obtained through simple mail or telephone reminder systems (Carter et al., 1991). Following are several examples of the early studies, many of which used an experimental design with random assignment to groups:

- Personalized letters urging high-risk elderly persons who had been hospitalized during the last year to get an influenza vaccination improved compliance from 30 percent (observed in a randomized control group) to 39 percent (Mullooly, 1987).
- Sending a reminder letter to the unvaccinated boosted immunization rates from 17 to 43 percent in one community health center over a one year period. Providing a telephone reminder to those not responding to the letter further increased vaccination coverage to 55 percent (Frank, 1985).
- In an experiment to test the relative effects of a letter urging unvaccinated high-risk individuals to get a flu shot and the letter plus an informational brochure, the combination of the letter and brochure proved more effective than the letter alone (36 versus 23 percent vaccination rates) (Carter et al., 1986).
- In an experiment testing telephone and mailed reminders, both kinds of reminders successfully motivated high risk individuals to obtain their influenza vaccination (Brimberry, 1988).
- According to another experiment, both telephone reminder calls made by a nurse and a reminder letter were more successful in motivating elderly persons to get vaccinated than a personal reminder by a physician (37 and 35 percent versus 23 percent immunized, respectively). Any of these interventions were better, however, than no intervention (10 percent immunized) (McDowell et al., 1986).

Some evidence suggests that new approaches will have to be tried as vaccination rates improve. Post card reminders to the elderly had no demonstrable effect when the baseline immunization rates were as high as 55 percent. Here, both cases and controls were exposed to a number of community-based educational interventions (e.g., television, radio, and newspaper messages) and the post-card reminders afforded no additional effect. It may be that different strategies will have to be implemented once a "ceiling" level of immunization is reached (Buchner, 1987).

In an analysis of why a new comprehensive health promotion and disease prevention program targeted to Medicare beneficiaries failed to attract them, blame was placed on the reliance on mail marketing to recruit participants. Usually, direct mail campaigns work well with seniors, but here, nearly one-half of those invited to receive free preventive services did not recall receiving the invitation letters (Laliberte et al., 1993).

Communication Strategies Targeted to Minority Populations

In 1994, one in ten elderly were of a race other than White, but by 2050, this proportion should double to an estimated one in five. The proportion of elderly who are Hispanic is expected to climb from 4 to 16 percent over the same period (i.e., 1994 to 2050) (U.S. Census Bureau, 1995). As of 1990, an estimated 3 percent of the elderly population did not speak English, or did not speak English well (1990 Census of Population and Housing, STF3 matrix (Table P028)), but this segment will grow as the elderly population becomes more ethnically and racially diverse.

The limited evidence on the communication strategies that most effectively work within various minority communities suggests that three methods work best: 1) using one-on-one personal communications; 2) targeting messages using culture- and language-specific media; and 3) initiating communication efforts through community-based organizations, such as churches and clubs.

Results of focus groups conducted in 1995 to learn about sources of health information among various minority populations indicated that churches, clinics, community organizations, and schools were identified as important sources by both Black and Hispanic groups. Informational sources common to all groups included doctors, family and friends, and magazines (Deering et al., 1996).

Four communication strategies were compared in a recent study to encourage Hispanic caregivers of relatives with Alzheimer's disease to seek assistance as part of a State-sponsored intervention program:

- Personally contacting programs already serving Hispanic families in the community and linking with their staff,
- Mailing flyers to community agencies serving the Hispanic elderly,
- Placing public service announcements in Spanish- and English-language newspapers targeted for specific areas, and
- Having public service announcements shown on local television or radio stations in the Spanish language.

Virtually all (61 of 64) of persons contacting the program were referred through persons in community-based programs, so the initial strategy of networking with available providers was determined to be the most successful communication strategy within this population (Gallagher-Thompson et al., 1994).

Strategies to overcoming barriers to service use among low-income minority elderly in Texas included: the use of opinion leaders within the community (e.g., the clergy, housing project managers, physicians); using multilingual forms; providing assistance in filling out forms; providing low cost transportation; reducing client donations for services; increasing minority group representation among providers; and sensitizing staff to minority group culture and values (Yeatts et al., 1992).

Select special needs subgroups will be inventoried as part of the HCFA Market Research for Beneficiaries project. Planned upcoming Inventory Reports will address the information needs of African Americans, Hispanic Americans, beneficiaries who live in rural locations, beneficiaries with low levels of education, hearing and visually impaired, dual eligibles, and individuals about to enroll in Medicare.

Communication Strategies to Promote Consumer Choice

Medicare beneficiaries are increasingly being asked to make choices about health plans based on quality and other performance measures. In a review of the practices of several private and public health insurance purchasers, four types of communication strategies were found to be especially effective in facilitating consumer choice (Hoy et al., 1996):

- Requiring plans to provide *comparable*, comprehensive health benefits; to provide objective and reliable information; and, to host a structured open enrollment period during which consumers make choices;
- Providing comprehensive information to support the choice process including information about benefit plan features, health plan structures and network access characteristics, health plan quality information, information about participating providers, and the price to the consumer of the health plan choices;
- Supporting the choice process with consumer education including an introduction to the concepts of managed care, the value of the consumer information provided, support for making trade-offs among plan features and choosing among plans, and administrative information necessary to complete the enrollment process; and
- Holding participating health plans accountable for meeting performance standards through the use of common reporting requirements and standard definitions of performance and standard objective measurement tools and processes.

In terms of the content and mode of delivery of consumer information, these investigators found that consumers require (Hoy et al., 1996):

- Several different kinds of information about the available options, including program and administrative information (e.g., enrollment forms and procedures) as well as individual plan characteristics, price, providers, and performance measures;

- Plan information in a single document and in side-by-side comparison tables;
- Easy access to detailed information about their health plan including detailed information about specialists and how health plans treat others with a specific condition;
- Toll-free numbers with access to the information or personnel who are trained to help the consumer figure out how to get the information that they want; and
- Information presented in as simple and as understandable way as possible and written in a language that typical consumers can understand, without legalistic benefits language or technical statistical terminology.

Many who are developing materials to promote consumer choice make two assumptions: 1) if we give consumers more information, they will be able to make better decisions; and, 2) consumers are able to weigh both cost and quality information as they make decisions. Evidence from decisionmaking research, however, challenges these two assumptions. This research suggests that providing more than five pieces of information actually reduces decisionmaking efficiency. Furthermore, when faced with complex information and competing objectives, individuals will give more weight to variables that are precisely described and concrete and give less weight to more abstract factors that are inherently harder to evaluate. This suggests that costs, which are precise, and widely understood may outweigh quality factors, as they tend to be vague and less well understood. Providing easy to understand, standardized information and offering decision support are two ways to maximize consumers' ability to make decisions that support their interests (Hibbard, 1996).

Current and Preferred Sources of Medicare Information

In this section, we review the elderly's use of various media, their current sources of Medicare information, and their stated preferences for receiving Medicare information.

The Elderly's Use of the Media and Communication Technologies

The elderly generally have more free time than others and so it is not surprising that they are heavy users of a number of different communication media. Television is the preferred media, which tends to be watched both for entertainment and for news. Some evidence suggests that adults over age 50 spend a median of over two and one-half hours per day watching television (Cronin, 1996). Some research suggests that the majority (83 percent) of adults age 55 to 75 have a VCR, however, this estimate may be high (Adler, 1996). Relatively fewer older adults listen to the radio, but older audiences can be reached by targeting certain types of programming, such as news or easy listening formats. The elderly are more likely to read daily newspapers than younger adults, but some evidence suggests that readership declines among those age 80 and older (W.R. Simmons & Associates Research, 1995; O'Keefe, 1990). Most adults over age 50 (70 percent) are magazine readers and households with older adults account for 40 percent or more of subscriptions to some health-related magazines, such as *Prevention* (Cronin, 1996).

With the proliferation of new information technologies, such as on-line computer services, it is reasonable to ask how appealing these modes would be for the elderly. Evidence suggests that for

a relatively large segment of the elderly population, new technologies might be a welcome source of information. Computer sales among consumers aged 65+ have grown faster than for any other age group. Estimates of computer use among seniors vary, depending upon the source and the group sampled (for example, on-line surveys are poor predictors of use due to self selection). Nearly one-third of adults age 55 to 75 own a personal computer (PC), according to a November 1995 survey (Adler, 1996). Among males 65 to 74, one third (32 percent) own a PC, and among males 75 and older, nearly one-quarter (23 percent) own one. Most seniors use their computers for word processing, but more than one-quarter describe themselves as regular users of on-line services. Another study suggests that senior citizens who own PCs are as likely to use their computers to surf the Internet as teenagers and college students (McCarthy, 1995). Even when seniors do not own a computer, most have access to one through their children (64 percent) or friends (36 percent). PC ownership increases with educational attainment. In fact, the majority (53 percent) of seniors who are college graduates have PCs. As the baby-boom generation ages, the educational attainment of seniors is expected to rise, and some project that the market penetration of PCs among older adults will be virtually indistinguishable from that in the general population (Adler, 1996; Census Brief, 1995). Nevertheless, for many seniors, cost, psychological fears, and computer illiteracy currently remain as barriers to computer use (Festervand et al., 1994).

How Medicare Beneficiaries Obtain Information About Medicare

Most (75 percent) beneficiaries report being able to obtain information about Medicare when needed (DHHS, OIG, June 1995), but barriers to getting needed information about Medicare include being unaware of resources, such as HCFA's toll-free telephone number, and inadequate accommodation for those with hearing impairments and those for whom English is not their primary language (DHHS, HCFA, MTS, 1995).

To obtain information about services that Medicare pays for, beneficiaries say they would most likely refer to *Your Medicare Handbook* (a HCFA publication), or obtain information from their doctor's office, the insurance company that processes their Medicare claims, or a Social Security office. Among those who have tried to obtain further information, two-thirds say that they were able to get the information most of the time (DHHS, OIG, June 1995).

HCFA publishes *Your Medicare Handbook* which comprehensively describes the program and how to obtain information. Other publications include a *Guide to Choosing a Nursing Home* and *A Guide to Health Insurance for People with Medicare*. Three-fourths (76 percent) of beneficiaries surveyed in 1994 said they knew about *Your Medicare Handbook* and most thought that it was helpful and easy to read (OIG, June 1995). Relatively few beneficiaries, however, are familiar with booklets about selecting a nursing home and supplemental Medicare coverage (Medigap policies), and fewer than three percent of beneficiaries reported actually using these guides (OIG, May 1994).

In 1994, about one-fourth (26 percent) of Medicare beneficiaries reported calling the insurance company that processes their claims. Although most (82 percent) reported being satisfied with the

service received when they called, many reported having difficulty getting through (30 percent reported having to try three or more times to get through or not getting through at all). More than one-third of those who had called the claims processor got an automated voice and the majority of those reaching an automated system could either not understand the directions provided or did not have a touch-tone telephone (DHHS, OIG, 1995).

Other sources of Medicare information frequently mentioned during focus groups held among Medicare beneficiaries include friends/relatives, doctor's office/medical staff; social security offices, senior centers, AARP, mail, newspapers/magazines, television, insurance agents, and state counseling programs (RTI, 1995; END, 1991).

Some differences in sources of Medicare information by sociodemographic group were noted in focus groups, and included the following:

- *Age*--Older beneficiaries (age 75 and older) frequent doctor's offices and so tend to rely on office medical staff more so than younger beneficiaries;
- *Educational attainment*--College educated beneficiaries tend to report using written materials, such as newspapers and magazines, whereas those with less than a high school education rank TV and doctor's office staff as their primary sources of information;
- *Race/ethnicity*--African Americans report using TV, while Hispanics report relying on Social Security offices as sources of Medicare information; and
- *Urban/rural residence*--Urban residents report greater reliance on TV, whereas rural residents rely more on AARP and mail for information.

When considering whether or not to join an HMO, Medicare beneficiaries appear to rely most heavily on word-of-mouth from an HMO member (Titus, 1982), family and friends, the media, personal contact with an HMO representative at an open house, and direct mail (Brown, Langwell and Ciemnecki, 1987; Ward and Bryant, 1986). Among the general population, friends and family members and employer benefits managers were the sources of information cited most often as helping to make a health plan decision (Louis Harris and Associates, 1995). In a recent Kaiser/AHCPR general population survey, the three most influential sources of information in choosing a health plan were doctors, friends or family members, and patients who are surveyed about their satisfaction with the quality of care (Kaiser/AHCPR, 1996).

Preferred Sources of Medicare Information

How would Medicare beneficiaries *prefer* to receive information about Medicare and which sources are most trusted? Results of three sets of focus groups held in 1995 indicate that Medicare beneficiaries overwhelmingly prefer personal group presentations or one-on-one personal counseling and, in addition, like to receive written information about plans, preferably printed in large type. Some participants said that they like to call Medicare directly for information. Other preferred sources of information included: senior centers; public libraries; post offices; county aging services agencies; and, Social Security offices. There was some interest

expressed in telephone hotlines, videotapes, and computer models, but concerns were also expressed over the technological aspects of these media (RTI, 1995; Frederick/Schneiders, 1995; Jorgensen, Maloney and Finn, 1995). In terms of credibility, focus group participants held mixed opinions on whether government agencies are credible sources of information and most felt that insurance plan representatives were not credible sources of plan information (RTI, 1995).

How HCFA's communications with beneficiaries could be improved was the subject of focus groups conducted for HCFA in 1995. Here, beneficiaries made several specific suggestions, especially in the area of telephone communications. Having a single 1-800-MEDICARE telephone number staffed with individuals who are well-trained to answer beneficiary questions about eligibility, claims processing, and coverage would eliminate considerable beneficiary confusion. There is some feeling that HCFA, the Social Security Administration (SSA), insurance carriers, and state-funded advocacy projects are all providing information, but that the information is not coordinated, comprehensive, and at times accessible. Beneficiaries using the SSA's 800 number often find that it can be difficult to get through, and while the SSA staff is knowledgeable about eligibility, they are not generally knowledgeable about Medicare claims processing or coverage. Insurance company 800 numbers can be difficult to access and are sometimes not accessible if you are out of the calling area (a problem for beneficiaries who are traveling or who have dual residences). Sometimes beneficiaries have to contact different insurance companies that are processing their claims. Some suggested that they would like to be able to have a single point of contact from which to obtain all information on Medicare, while others suggested a need to improve outreach efforts and increase the availability of service representatives in their communities (DHHS, HCFA, MTS, 1995). In summary, according to these focus groups, beneficiaries seem to want two things: a single comprehensive telephone source of Medicare information and in-person opportunities to learn about Medicare within their own communities.

The Automated Response Units (ARUs) that HCFA has used were not popular with focus group attendees. These units, which provide prerecorded information about Medicare which can be accessed by an 800 number, were described as intimidating and frustrating. Most beneficiaries preferred being able to discuss their problem with a knowledgeable staff person, although some did feel that the ARUs are potentially useful to obtain basic coverage information. There was a general feeling that an informational kiosk similar to an automated teller machine would be a preferable source (DHHS, HCFA, MTS, 1995).

Earlier focus groups held among Medicare beneficiaries (conducted by Mellman, Lazarus, and Lake for the Kaiser Family Foundation in 1993) had also indicated that the Medicare program could improve its communication with beneficiaries through the same two person-to-person methods: a single comprehensive telephone source and in-person meetings. Participants were also interested in attending seminars, because this format affords the opportunity to obtain answers to specific questions. Participants reported mixed feelings about videos and cable television as methods of disseminating Medicare-related information.

Preferred sources of Medicare information mentioned in focus groups conducted earlier in 1991 include sources of health care, such as doctor's offices and hospitals. Because beneficiaries sign

up for Medicare through Social Security offices they tend to view them positively as sources of information. Although AARP was often cited as a current source of information, beneficiaries did not rate the organization highly as a preferred source of information because of its commercial orientation (many insurance products are advertised in AARP publications). Many liked TV as an informational medium, and these participants suggested video-cassettes available through senior centers or libraries. There was some evidence that preferences varied by age, gender, educational attainment, and race/ethnicity (ERD, 1991):

- *Age*--Beneficiaries over age 75 rank AARP more highly than younger beneficiaries as a preferred source of information;
- *Gender*--Women tend to prefer doctor's offices as sources of information whereas men are more likely to prefer AARP;
- *Educational attainment*-- While differences exist between actual sources of information by education level, there were no differences in preferred sources of information by educational attainment; and,
- *Race/ethnicity*--African Americans are more likely to both prefer and use television, but while Hispanics report using local Social Security offices for information, they report preferring the mail as a source of Medicare information.

There have been a number of changes to the Medicare program in recent years and the three most preferred ways of getting information about these changes mentioned in the 1994 Office of the Inspector General survey were:

- Pamphlets describing the changes (39 percent),
- A new Medicare Handbook (37 percent), and
- A notice included with the Social Security check (17 percent).

Relatively few (5 percent) preferred to be notified of Medicare changes via announcements on television and radio (DHHS, OIG, 1995).

For a regional perspective, a 1996 survey conducted with Medicare beneficiaries in Texas suggests that educational outreach could be enhanced by using update letters, bulletins, and *Your Medicare Handbook*. One in five seniors reported that senior citizen centers would be the venue for attracting large numbers of beneficiaries for informational meetings. Nearly two-thirds of respondents (63 percent) expressed interest in attending a lecture that provided time for questions and answers (Wolfe, The Gallup Organization, 1996).

The particular needs of beneficiaries in the area of print media are illustrated in the development of the Explanation of Medicare Benefits form (EOMB). The EOMB explains to the beneficiary how their medical claims were handled and tells them what, if anything, they have to pay for rendered services. The form has been revised several times in response to beneficiary assertions that it was too complicated and not formatted clearly (PPRC, 1989; Westat, 1993). The form has

recently been revised once again in response to beneficiary feedback regarding print size that is too small and hard to read because of gray background shading, the calculation of the amount that Medicare pays as it has several steps and is confusing, and language that is sometimes too technical to understand (DHHS, HCFA, May 1995).

Health Communication and New Technologies

Communicating with health care consumers is a rapidly growing academic field and an equally fast-growing industry. New and emerging technologies, such as increasingly user-friendly computer software, the Internet, telephony systems (i.e., the integration of telephone and computer technology), and interactive television, have allowed the development of new models of communicating with particular populations such as members of an HMO or persons with a specific chronic condition. This section of the report provides an introduction to some of the innovations in communicating health information as well as a new conceptual framework. Although persons currently eligible for Medicare are typically slower than the general population to embrace new communication technologies, the rapid growth of these technologies indicates that the Medicare population will be increasingly affected in coming years. Further, as new cohorts become Medicare eligible, the proportion of beneficiaries familiar with these media will increase.

The revolution in health communication technology has led to a new conceptual framework within economic health policy: "demand management."

> Demand management may be defined as *the support of individuals so that they can make rational health and medical decisions based on a consideration of the benefits and risks of the options available. (Vickery, 1995)*

The cornerstone of demand management is an informed consumer of health care services who acts in partnership with medical providers to *manage* his or her own health. Examples of demand management tools are diverse and far ranging, and include health risk appraisals, written and audiovisual media, telephone counseling services, and community resources (OTA, 1995). Other examples of community-based vehicles for providing a "high touch" and intensive interaction that enables the beneficiary to actively participate in managing his or her health are Retired Senior Volunteer Program (RSVP), in which seniors work with other seniors, and the Interfaith Volunteer Caregiving Programs. The outcomes of demand management should be, its proponents argue, reduced health care costs and improved health. Since these objectives closely parallel those of HCFA, it follows that if demand management techniques fulfill their promise, they would be appropriate for incorporation into HCFA communication strategy.

Demand management promises to become a widely used strategy among managed care plans. As described by Lazarus (1995), medical call centers represent one product increasingly being used to achieve demand management. These after-hours centers provide medical advice and triage to plan members over the telephone, in theory reducing the demand for costly emergency services. The Harvard Health Plan (HHP) has taken this concept one step further (Zallen, 1995), in a recent

pilot project. HHP placed computer terminals in the homes of members in one community through which members could access the "Triage and Education System." The system allowed them to access a health library or to go through an illness protocol, a kind of expert decision system that prompted the member for specific information about a health problem. Depending upon the member's responses, the system either provided self-care advice or referred the problem, with a priority rating, to "live" reviewers.

The Home Health Workstation, also called the Comprehensive Health Enhancement Support System (CHESS), is a highly targeted demand management system developed at the University of Wisconsin (Gustafson, 1996; Gustafson et al., 1993). This system has been developed for: people newly diagnosed with life-threatening illnesses, including AIDS and breast cancer; children of alcoholics; and, other groups. At diagnosis, patients are sent home with a computer including all the necessary software to run the system. The system's main menu includes the following options:

- Frequently asked questions;
- Medical articles related to the specific illness (about 150 articles, for the breast cancer system);
- Services available (more than 300);
- Personal stories from other patients;
- An e-mail "ask an expert" feature;
- Discussion groups;
- Decisions and conflicts;
- Developing an action plan;
- Assessment, referrals, and a CHESS dictionary; and
- Health charts to be completed every two weeks by the patient, which can be used both by the patient and providers.

Experience with the CHESS technology has been very positive, with a majority of users citing the possibility of group interactions, either by e-mail or discussion groups. The sickest patients tend to use the system most frequently and almost half of its use is between the hours of 10 p.m. and 6 a.m. Minority patients have used the system as frequently as white. Less educated patients have used it as much as more educated, although the types of use vary by education level (McTavish et al., 1995). While CHESS has not reduced the number of physician visits or hospital stays in its trials, it has reduced the amount of time spent with the physician and the length of the hospital stays.

At the 1996 Department of Health and Human Services-sponsored conference entitled "Partnerships for Networked Health Consumer Health Information," representatives from the for-profit sector, including mass media companies, pharmaceutical manufacturers, managed care

plans, and technology boutiques, convened to discuss consumer health information networks (U.S. DHHS et al., May 1996). A common theme of presenters at the "Partnerships" conference was that consumers most want and can best understand information that is presented to them interactively. The traditional method of interactive information gathering is talking with individuals--friends and family, medical providers, health plan representatives, and "people like me" in support groups or other venues. Computing technology, and particularly the Internet, has expanded the notion of interactive information gathering. Consumers can research virtually any health problem on the Internet, and on-line services offer forums, chat groups, events with speakers, and bulletin boards for people with special interests, such as those suffering from a particular serious illness (Deering, 1996).

Ferguson (1996) presents a comprehensive look at such on-line self-help groups, which may or may not include medical professionals, and provides a very positive view of the effects of participation in such groups. America On-Line has forums on more than 50 medical topics. America's HouseCall Network, which markets on-line health information to managed care organizations, lists 20 areas of interest for health-related bulletin boards. Compuserve has recently started a service called "Health Answers." SeniorNet is a nonprofit organization whose mission is to build a community of computer-using seniors. The group has established computer learning centers in nearly 90 areas throughout the country (www.SeniorNet.org; Furlong, 1989). There is some evidence that computer-based systems designed to be easy to use with meaningful applications can be adopted relatively easily by the elderly, even those with no prior computer experience (Czaja et al, 1993). Both the Partnerships conference and throughout the popular literature, there are mentions of anecdotal "success stories" from on-line self-help groups--people who found treatment alternatives and/or support via the Internet.

Ferguson notes that most self-help on-line groups have compiled lists of "frequently asked questions" (FAQs) that new or prospective users can access to obtain basic information about what is going on with the group. The FAQ approach appears to be a successful method of providing passive (as opposed to interactive) information on-line. (At HCFA, staff from the Office of Beneficiary Relations (OBR) noted that a booklet with 85 questions and answers about Medicare was, anecdotally, OBR's most popular publication at information booth exhibits.)

While conference participants were generally very excited about on-line health information, many expressed concerns about the reliability of information available on the Internet. One natural method used by information consumers is to look for "brand names," or certification by a known source that information is reliable. This kind of certification is one possible role for Federal agencies, including HCFA, in the new information dissemination technologies. The comparability charts provided by HCFA represent an example of a successful effort whereby useful information is conveyed about the features of various plans which enables more informed consumer decisionmaking.

Success stories all describe patients who become empowered health consumers, working with medical providers to manage their own health care, or at least those providers who are open to this collegial relationship. Another perspective at the Partnerships conference was from the

provider side. As described by Rockefeller (1996), a growing number of physicians realize that they can not possibly keep up with all of the information that may be relevant to treating their patients. Such physicians welcome the idea of informed patients, and some go so far as to see the computer as a third party in patient-physician consultations.

There are many barriers to widespread use of the Internet and other interactive technologies. One important barrier is the need for a computer or terminal in the home. The cost currently is prohibitive for many persons, and for others "home" is not a single location conducive to keeping such a piece of hardware. Two approaches to overcoming this barrier are publicly available computer systems, such as "kiosks," and use of the telephone in lieu of a computer or terminal.

Computer-based health information systems have been made available in public spaces, such as workplaces and public libraries. As early as 1975, employees at RCA used information kiosks to get information about their health plans and health care (O'Donnell, 1996). While employees were generally very favorable, a kiosk in a public place can be inhibiting, and a workplace location means that family members may not have access. With the increased use of personal computers in individual offices and at home, home-work linkages and Intranet systems can help overcome these problems (Intranet systems are closed Internet systems). One publicly-based system is the New York On-line Access to Health (NOAH), a World Wide Web site accessible from many of New York City's public libraries. This system has assembled access to information from the National Cancer Institute and from many New York agencies and providers (Dehner and Leger, 1996). Other comparable library-based information systems include the SAILOR program in Maryland and Pennsylvania's state-wide program linking older adults with local library services, such as the creation of booklists of materials of special interest, a mini-bookmobile, a fax information exchange service, and the use of closed-circuit television magnifiers to enlarge materials for those with visual impairments (Perspective on Aging, 1994).

Computer networking has been used successfully to link individuals who have difficulties with getting out into the community (e.g., those with disabilities, home family caregivers) to family, health care providers, and to sources of clinical and other information now available on-line (Noer, 1995; Brennan et al, 1994). A number of commercial on-line products (e.g., Net Wellness, WellNet) are being marketed to employers and health plans to assist in their efforts to promote prevention, and the appropriate use of health care. The federal government is another major source of on-line information, providing clearinghouses, like the National Health Information Center; Web home pages; and, specific electronic products, like the National Cancer Institute's PDQ databases from the National Library of Medicine and the Office of Disease Prevention and Health Promotion's Put Prevention into Practice (Deering, 1996). For rural and inner-city residents, Microsoft has joined with local libraries to provide direct consumer access to computers and on-line services through the Libraries On-Line program.

Publicly available information kiosks have been developed by Benova (under a DHHS-AHCPR-SBIR contract) and others to provide information about health promotion, health care, and health insurance plans. The Benova kiosks are currently being evaluated as decisionmaking aids for Medicaid beneficiaries who are choosing a managed care health plan. The kiosk employs a touch-

screen and shows comparative information about plans, such as affiliated hospitals and providers and satisfaction survey results (Adatto, 1996).

A telephone-based health information system has been developed at Cleveland State University (Alemi, 1996). This system is being tested with 4,000 new mothers in Cleveland and several other settings, including with a sample of 80 cocaine using, pregnant women. It has many of the same features of the CHESS system described earlier, including access to mail, bulletin boards, decision aids, libraries, and triage and assessment. Patients are asked to call the "telepractice" at the time they make their first appointment and go through an automated screening interview. The results of this interview are later available to the clinician at the time of their visit. Patients are encouraged to use the system to obtain information, ask questions, learn about other people in their situation, and get help managing their own health. The results have been positive, although the tests have been limited in scope.

Interactive television holds the promise of delivering health promotional messages, but much of the public does not know how it can be used and few are interested in paying for it, especially the elderly. Nevertheless, companies are investing in this technology and a variety of commercial applications are forthcoming, including on-demand movies or programming, travel services, and home shopping (*Advertising Age*, 1993).

Summary

Considerable research has been undertaken over the last ten years in order to understand Medicare beneficiaries' preferences and levels of knowledge regarding Medicare. The HCFA Market Research for Beneficiaries" project provides a vehicle for synthesizing this research, and using it to scaffold its own data collection. This report contains the findings regarding the information needs of the general Medicare population and a summary of "best practices" for developing an integrated communication strategy to provide the requisite information to beneficiaries.

Key findings from previous research relate to the content and dissemination of information to an increasingly diverse population of beneficiaries. Most research suggests that the levels of beneficiary knowledge vary, with some beneficiaries being extremely knowledgeable and sophisticated, and others knowing very little. In general, beneficiaries are less familiar with features of Medicare that have recently been implemented. The literature suggests that beneficiaries need:

- Descriptive information about Medicare (both general and detailed) and how it works;
- Information about their insurance options (such as managed care, or fee-for-service and supplemental plans);
- Information about providers and how to choose them; and
- Information to help them identify their preferences and make the tradeoffs among cost, quality, and access.

The literature suggests that one key to successful information dissemination is for HCFA to provide a broad structure, within which different, more tailored activities can occur. Beneficiaries prefer a multi-method communication strategy which includes written materials that they can keep and use as a reference, a toll-free telephone number on which they can speak to a live, trained operator, and interactive person-to-person exchanges, such as small group seminars or meetings, or one-on-one counseling sessions in which they can ask questions about their specific situation. There is evidence that new technologies are showing promise as vehicles for differentiated information dissemination, such as the Internet, especially for future generations of beneficiaries.

INTERVIEWS: FINDINGS AND IMPLICATIONS

Interviews conducted for the inventory provide a mechanism for drawing information from diverse organizations and individuals about the health information needs of the elderly, ways of determining information needs, effective strategies for communication of the information, and methods of outreach and education to encourage information-seeking behavior. The interviews "update" and expand the findings from the literature review. While the research is all fairly recent, the 1990s have been a time of rapid change, both in the structure of the health care market and in communication technologies, and the interviews provide the HCFA the opportunity to obtain a "reality-check." The interviews also enable HCFA to obtain the opinions and insights from experts in health communication who work regularly with seniors and have grappled with the various barriers to effective communication with them. They are able to provide critical insights into the day-to-day reality and concerns of the Medicare population.

We worked closely with both HCFA staff and the Technical Advisory Panel for the project to identify individuals and organizations that could offer relevant information on developing effective communication strategies. Additionally, organizations were identified through the literature review. The preliminary list included regional HCFA offices, local Medicare advocacy and counseling programs, Medicare carriers and fiscal intermediaries, and Medicaid and Medicare managed care plans. The goal of contacts with these entities was to learn about the characteristics of effective and ineffective communication strategies with Medicare beneficiaries. In addition, Federal agencies and private corporations that were known to employ innovative communication strategies for providing customer service were interviewed to identify "best practices" in communication that could be applied to HCFA's situation. Interviews were conducted in and around Washington DC and in targeted cities, chosen to represent different geographic regions, including Chicago, Miami, New York, Philadelphia, and Seattle. By including many different types of organizations and conducting in-depth interviews, we were able to obtain multiple perspectives on how best to reach beneficiaries. Table 2 below contains a list of organizations and individuals interviewed for the inventory organized by type, as well as by geographic location.

Whenever possible, we sought multiple perspectives, whether this was accomplished through interviewing headquarters and the local office of an organization or two separate functions within the same organization. Additionally, multiple interviews with ICAs and AARP were conducted, at different geographic locations, in order to understand how regional variation impacted both program operations and communication strategies.

Table 2. Organizations and Individuals Interviewed for HCFA On-Line Inventory

Organization	Location
Health Care Financing Administration -HCFA	
Bureau of Program Operations, Office of Customer Communications	Baltimore, MD
Executive Secretariat	Baltimore, MD
Office of Beneficiary Relations	Baltimore, MD
Office of Managed Care	Baltimore, MD
HCFA On-Line Staff	Baltimore, MD
HCFA Regional Office	Chicago, IL
HCFA Regional Office, Teleservice Pilot Program	Philadelphia, PA
HCFA Regional Office, Medicare Center Pilot Project	Philadelphia, PA
HCFA Regional Office	New York, NY
HCFA Regional Office	Seattle, WA
Operation Restore Trust	Miami, FL
Federal Agencies	
Centers for Disease Control	Atlanta, GA
CHAMPUS - TRICARE	Denver, CO; Silver Spring, MD; Alexandria, VA
Office of Personnel Management, Federal Employees Health Benefit Plan Program	Washington, DC
Food Stamp Program	Alexandria, VA
Social Security Administration	Washington, DC
Veterans Health Administration	Washington, DC
State or Local Agencies - Senior Organizations	
Administration on Aging	Washington, DC
Chicago Department on Aging	Chicago, IL
Florida Medical Quality Assurance Inc. (PRO)	Miami, FL
SHIBA Project (ICA)	Olympia, WA
SHINE Project - Alliance for Aging, Inc. (ICA)	Miami, FL
Illinois Department of Insurance, SHIP (ICA)	Chicago, IL
Medicare Rights Center (ICA)	New York, NY
Health Insurance Counseling Project (ICA)	Washington, DC
Membership Organizations	
American Association of Retired Persons (AARP)	Washington, DC
American Association of Retired Persons (AARP)	Chicago, IL
American Association of Retired Persons (AARP)	Miami, FL
Communications Workers of America	Washington, DC
Institute for Puerto Rican and Hispanic Elderly	Washington, DC
National Caucus and Center on Black Aged, Inc.	Washington, DC
Advisory Council to the Division on Aging	Seattle, WA
Older Women's League - Seattle-King County Chapter	Seattle, WA
Puget Sound Council of Senior Citizens	Seattle, WA
Seattle-King County Senior Citizens Communications Network	Seattle, WA

Table 2. (continued)

Organization	Location
Medicare Carriers	
Aetna Health Plans	Seattle, WA
Blue Cross and Blue Shield of Florida	Miami, FL
Empire Blue Cross and Blue Shield (Medicare Services)	New York, NY
Health Care Services Corporation	Chicago, IL
Trailblazer Health Enterprises, Inc.	Baltimore, MD
Medicare Insurers and Risk Contractors	
AvMed Health Plans	Miami, FL
Blue Cross/ Blue Shield of Illinois	Chicago, IL
Group Health Cooperative of Puget Sound	Seattle, WA
Health Insurance Plan of Greater New York	New York, NY
Keystone Health Plan East	Philadelphia, PA
United Health Care	Miami, FL
Corporations and Private Organizations	
AT&T, Managed Care Administration and Employee Education	New York, NY
General Electric	Fairfield, CT
GTE Health Care Management Group	Stamford, CT
Hewitt and Associates	New York, NY
Institute for Health Policy Solutions	Alexandria, VA
Keystone-Mercy Health Plan	Philadelphia, PA
KPMG Peat Marwick - Human Resources	Washington, DC
KPMG Peat Marwick - Human Resources	Montvale, NJ
Mercer	Stamford, CT
Merrill Lynch	New York, NY
Motorola	Chicago, IL
Nordstrom	Seattle, WA
TIAA-CREF	New York, NY
Time Life Medical	New York, NY
United Airlines	Chicago, IL
University of Miami	Miami, FL
XEROX, Human Resources Communications	Stamford, CT
Individual Consultants	
Dolores Perin, Reading Specialist Program, Teachers College	New York, NY
Carol Cronin, *Health Pages*	Annapolis, MD

Interview Protocols

Separate protocols were designed for each type of organization. Although each interview was designed to focus on the two basic research questions, other questions were included in order to provide context about the organization and its mission. For example, for interviews with carriers and Medicare risk contractors, a description of the plan's services or benefits and organizational structure was requested. We wanted to understand which departments handled Medicare customers, if and how the information was used in quality improvement, whether customer inquiry was tracked, and how often communication strategies were evaluated. We asked about outreach and education efforts that were structured to reach special populations. Additionally,

questions were asked to differentiate the information needed by beneficiaries about the Medicare program from the information that was needed about specific aspects of the benefits offered by the plan.

The interview protocol for ICA grantees was designed to collect information specifically about counseling the Medicare beneficiary who has questions about insurance. The ICA is impartial and expresses no particular preference about the option the beneficiary ultimately selects. Instead, the focus of the counseling is on helping the beneficiary think about or frame the problem, evaluate all of the options, and find the best solution for him or herself. Because ICAs typically use the services of volunteers, we were particularly interested in how they train volunteers and provide them with ongoing support. Additionally, we asked about the internal processes by which ICAs design and implement their communication strategies. The protocol for federal agencies was designed to gather information on strategies used to improve customer service and to understand the needs of their program beneficiaries. The protocol for senior groups included a description of the program or services offered, how the group identifies the most important issues to seniors, and how programs or activities are developed.

- Respondents observed that the most frequently cited information gap for both current Medicare beneficiaries and soon-to-be beneficiaries is managed care.
- Medicare beneficiaries, during 1996, were anxious and fearful of the future of the Medicare program.

In the next section, we present the findings from our interviews. We have organized them around the two research questions that are at the heart of the HCFA market research:

- What information do Medicare beneficiaries want and need from HCFA?, and
- How can HCFA best provide that information to them?

In order to answer the first question, we gathered material on the type of information beneficiaries want or need for effective decisionmaking, as well as how organizations determine the information needs of their constituents. In other words, we were interested in *how* the organization gathered and utilized data to either target its communications and/or be responsive to the needs of the recipients of the message, as well as the actual data they gathered. In organizing communication strategies, we organized them on their being either interactive or non-interactive, and by the purpose of the activity, such as advertising, targeted information delivery, promotion, and/or person-to-person exchange of information.

What Do Beneficiaries Want or Need to Know About Medicare?

Respondents noted that Medicare beneficiaries generally have questions about, and are confused by, certain features of the Medicare program. Questions range in complexity from "What is Medicare?" to "What is assignment?" to "How is the quality of care rated for plan XX?" to "Procedure XX was just approved by the Food and Drug Administration, when will Medicare

begin covering it?" This section summarizes what we learned about the information needs of both the about-to-enroll Medicare beneficiary and the current beneficiary in the following areas: the current Medicare program, such as covered services; different delivery systems for receiving health care; choosing a provider, cost and quality; supplemental policies, and preventive services. A point raised by one interview respondent is that it would be useful to differentiate the needs of individuals who are not receiving information from those who do not understand the information received, either due to format, language, or text complexity. Another useful conceptual distinction is between a beneficiary who knows what to ask, but does not know where to get the information, versus a beneficiary who does not know the questions to ask.

Our interviews with organizations that are in direct contact with Medicare beneficiaries also highlighted that, throughout 1996, Medicare beneficiaries were anxious and fearful of the future status of the Medicare program. Consequently, many recent questions by Medicare beneficiaries were aimed at seeking information and assurance of the steps being taken to preserve the program.

The Basic Medicare Program

A recurring theme from the organizations we interviewed is that many Medicare beneficiaries do not understand the basic Medicare program. As one interviewee noted, "...research has found that beneficiaries need a source of basic information about Medicare because beneficiaries generally do not refer to *Your Medicare Handbook* until they need to obtain specific services. Most beneficiaries are uneducated about the program as a whole."

- Respondents noted that many of their clients believe SSA administers the Medicare program, rather than HCFA.
- Minorities and low-income individuals are confused by the plurality of the US health care system, as well as the complexity of the interactions between available programs that can assist them.
- Many employers currently do not provide detailed information on the Medicare program to their retirees.

A common question received by regional HCFA offices, ICAs, state and local agencies, and member organizations is "What is Medicare?" and "What is the difference between government and Medicare?" Interviewees said that beneficiaries are generally unaware that HCFA administers the Medicare program, and often believe it is the Social Security Administration. This may, in part, be attributable to the fact that it is in the local Social Security Administration office that one applies for Medicare, and that premiums for Part B are commonly deducted from an individual's Social Security check. Indeed, respondents commented that beneficiaries often think that SSA and HCFA are the same entity.

An interesting observation that was made during a site visit is that Medicare beneficiaries often confuse Medicare Part A and Medicare Part B with the standard Medigap policies that are also labeled as "A" and "B". The confusion results simply from the fact that both are labeled "A" and "B". A beneficiary who has a deeper understanding of the program, however, might not be

confused by the labeling, recognizing that there are Medigap policies "E", "F", and so forth, and that the uniformity of the labeling facilitates a comparison across carriers.

One source of confusion exists around the mailing of HCFA's *Your Medicare Handbook*. While the handbook is generally seen as a useful resource tool, several interviewees commented that individuals turning 65 receive a great deal of information by mail at that time, so a notice that precedes *Your Medicare Handbook* (saying it is coming, why it is useful, and to look for it) might help beneficiaries better attend to it when it arrives. HCFA is revising the Initial Enrollment Package as the agency takes on responsibility for its distribution from SSA.

Organizations that assist minorities or low-income individuals had several helpful insights about the information needs of these particular individuals. For instance, in South Florida it is apparent that individuals coming from a country with a history of providing social security, health benefits, food stamps, and housing through one central government agency are quite confused by the plurality of the United State's health care system. While a dual eligible may be aware that services are covered and paid for, they do not realize that Medicare and Medicaid are different programs handled by different areas of government (i.e., Federal and State agencies). Some individuals are hesitant to call SSA or HCFA because they do not know which of many telephone numbers to use, and often receive answers only after placing numerous frustrating calls.

Low income elderly often have difficulty understanding the interactions between available public programs, and that eligibility in one program could affect eligibility in another program. These individuals need to be able to understand not only the eligibility requirements of the Medicare program, but also the requirements of the individual state (for Medicaid). The complexities of the interrelationship among a comprehensive set of entitlement programs can be overwhelming to them. In addition, it is often difficult for these individuals to extrapolate abstract requirements for entitlement to their own personal situation. Further, confusion is created by the fact that programs are often referred to by different names in different states, for example, states have different names for the QMB program.

A factor contributing to beneficiary confusion is that many employers currently do not provide detailed information on the Medicare program, the steps involved in enrolling in Medicare, and how employer-based benefits are coordinated with Medicare. Often, the focus of pre-retirement seminars is on financial planning rather than on future health care coverage. More often than not, private organizations refer individuals directly to SSA or to HCFA to have their questions answered. As one advocacy group noted, it provides pre-retirement services because companies are not doing an effective job of explaining the coordination of their company's benefits with Medicare. Individuals, especially minorities, do not understand their retirement benefits, that they must actively enroll to receive Medicare or Social Security benefits, or that they can receive assistance in obtaining the needed information.

Medicare Costs

Interviews suggested that beneficiaries are often confused about issues related to payment for Medicare covered services. Respondents often remarked that beneficiaries want to know the bottom line--"What is my total cost for the benefits that I will receive?" Common beneficiary questions regarding costs include claim status, deductibles, primary versus secondary payer, the EOMB statement, and assignment/participating providers. From the interviews it was clear that confusion about the issue of cost is usually due to a lack of *understanding,* than a lack of information. As such, the issue for HCFA becomes one of modifying existing communication strategies, rather than creating additional avenues to reach beneficiaries. Common beneficiary questions about the costs associated with Medicare include:

Beneficiaries in fee-for-service and/or purchasing Medigap policies often ask questions about the:

- Status of their claims
- Deductible amounts
- Medicare as a secondary versus primary payer
- EOMB statement
- Assignment/Medicare participating provider

- Claim Status. Typical questions are: How much do I owe? How much does Medicare cover? Where in the queue is my claim? When can I expect to receive it? Why was my claim denied? These questions are generally handled by the Medicare carrier for the state. Regional HCFA offices become involved when they have received a written inquiry from the beneficiary or from a beneficiary's congressional representative.
- Deductible. An area of confusion for Medicare beneficiaries, especially ones that have not previously had health insurance, is the deductible. Many do not understand why they have to pay for services "that Medicare covers" before they have reached their deductible. This situation is further aggravated when providers request payment for the deductible prior to rendering service. One carrier cited an example of a common situation to illustrate the point: A beneficiary visits his or her physician at the beginning of January and pays the required deductible amount. With this payment, the beneficiary reaches the $100 deductible. However, either because of the time to process the claim or because the physician might not file the claim in a timely manner, when the beneficiary later visits a specialist, for example, the specialist also requests the deductible. At this point, the beneficiary is confused--he or she knows that the maximum out-of-pocket deductible has been reached--but rather than confront the physician or enter into a perceived confrontation, the beneficiary will typically pay the specialist as well. Beneficiaries typically do not know that the provider is supposed to bill Medicare, and then if there is unmet deductible, bill the patient for the deductible.
- Medicare as the Primary vs. Secondary Payer. Not all Medicare beneficiaries understand the concept of Medicare as a secondary payer. They do not understand the circumstances in which Medicare does not pay for a service that the beneficiary thought was "covered"-- in other words, Medicare does not pay because the other health insurance is the primary payer

and Medicare is the secondary payer. Further, beneficiaries become upset by the personal questions a physician's office asks them, such as "Is your spouse still working?"; "Is your spouse covered by health insurance?"; "Are you covered under this policy?" In response to this concern, one carrier created a flow chart to help explain the concept of Medicare as the secondary payer.

- The EOMB Statement. Medicare beneficiaries often see the EOMB statement as a bill, in part because the EOMB statement resembles a bill in appearance, and uses technical terms they do not understand or cannot comprehend. Their first reaction is to be concerned that they owe money. Further concern is induced when the beneficiary receives a separate accounting from a hospital--this statement is also seen as a bill. Several interviewees who use *Your Medicare Handbook* as a resource noted that the information in the handbook regarding the EOMB is too general and does not include a graphic example of what a beneficiary should expect. However, one site visit participant stated that much of the confusion around the EOMB will be reduced once the Medicare Transaction System becomes operational. HCFA is also developing a summary statement which should help beneficiaries.
- Assignment/Medicare Participating Provider. Respondents noted a common concern among Medicare beneficiaries regarding choosing a provider. While beneficiaries may understand the concept of assignment, they often do not understand that if a physician is not "participating", that physician can charge up to 15 percent more than the Medicare allowable charge, and that the beneficiary is responsible for paying it.

Covered Services

Beneficiaries often seek information regarding the specifics of Medicare coverage, as well as services Medicare does not cover. For covered services, beneficiaries generally seek clarification about durable medical equipment; skilled nursing facilities; and home care. For services not covered by Medicare, beneficiaries often ask about prescription drugs and ambulance transportation. In several locations, it was noted that Medicare beneficiaries who are particularly savvy and follow the approval of medical treatments and/or medical devices by the FDA inquire when particular treatments will be covered by the Medicare program.

- The hospital-issued Notice of Noncoverage is an abstract concept to some beneficiaries, and they do not understand they can appeal it.
- Beneficiaries are willing to report suspected fraud and abuse, but often do not know who to call to report it.
- Growing trend is for questions to be asked by a beneficiary's family member(s).

One issue that interviewees noted is that beneficiaries are consistently confused by the hospital-issued Notice of Noncoverage (as well as the EOMB, see below for a discussion). To many beneficiaries, "noncoverage" is an abstract concept that they do not understand. Further, they do not realize that they have the right to appeal the hospital's noncoverage decision.

Another area of confusion centers around fraud and abuse or, in more specific terms, how and where a beneficiary can lodge a complaint. Predominantly, we heard that beneficiaries are willing to report suspected cases of fraud and abuse but that they often do not know who to call to report it. Medicare carriers typically are notified of suspicious billings for services the beneficiary believes he or she did not receive. However, it was noted by several interviewees that Medicare beneficiaries are not knowledgeable about the various forms of Medicare fraud and abuse, such as that HCFA does not "endorse" any services or products; that one's Medicare number is not for sale; and that one should be suspicious if a provider offers services for "free." Several HCFA regional offices and the State of Florida, through Operation Restore Trust, now operate toll-free hot lines that beneficiaries can call to report suspected incidences of fraud and abuse. On a related note of suspicious activities, some interviewees noted that beneficiaries are confused or suspicious when they receive calls asking them to take part in a health survey or related activity.

There appears to be a growing trend for the questions to be asked by a beneficiary's family member (i.e., "What are my father's Medicare benefits?"). For example, one carrier noted that it had experienced a nine percent increase in its "General Inquiry" category of calls received, with one-third of these calls being attributable to family members of the beneficiary. Family members usually ask general Part B questions.

Fee-For-Service Medicare and Supplemental Insurance

Individuals about to turn age 65, or just turning age 65, are immediately confronted with the decision about whether they should sign up for Medicare Part B, and whether to purchase Medicare Supplemental insurance. Individuals living in certain parts of the country, primarily urban areas, can also now choose between traditional fee-for-service Medicare and managed care organizations, both risk-based and cost-based. In making these decisions, the beneficiary has to consider his or her personal circumstances. It was noted, particularly by ICAs and member organizations, that both beneficiaries and about-to-enroll beneficiaries often seek assistance in deciding which delivery system will best suit their needs.

Respondents who have regular and direct contact with beneficiaries report that beneficiaries often do not understand the supplemental insurance policies that they have purchased and how their supplemental coverage interacts with their Medicare coverage. Beneficiaries usually seek assistance in understanding the actual terms of the supplemental coverage and what services they are entitled to receive. An indication of their confusion is that interviewees reported anecdotal incidents of beneficiaries' having purchased more than one supplemental insurance product, thinking they were now covered for specific services the first policy did not cover.

Although not related to Medicare or Medigap policies, beneficiaries also seek assistance in selecting long-term care and nursing home insurance. Beneficiaries are becoming more interested in these policies as they do not want to leave their family members with high medical bills.

Managed Care

"Managed care" is one of the most important and frequently cited informational gaps for both current and about-to-enroll Medicare beneficiaries. Since most beneficiaries are accustomed to a strictly fee-for-service health care delivery environment, the concept of managed care is foreign to many of them. In addition, the number of Medicare HMOs available to beneficiaries has increased dramatically in recent years--for instance, there were 83 HMOs operating under risk contracts in 1992 (representing 3.5 percent of Medicare beneficiaries); by August of 1996, the number of HMOs operating under risk contracts had increased to 229 and represented approximately 10 percent of Medicare beneficiaries.

- Managed care is an important informational gap among beneficiaries.
- Confusion results from the term "Medicare managed care", with many thinking that "Medicare + Supplemental Insurance = Medicare managed care".
- Level of general understanding of managed care influenced by regional differences, including market presence of HMOs and length of time an HMO has been serving an area.
- Some beneficiaries erroneously think that the "zero premium" advertised by some HMOs means they do not have to continue to pay the Part B premium to HCFA.

One organization we interviewed has prepared a one page fact sheet on managed care models that provides definitions of the following terms: Cost HMO; Direct Contract Model HMO; Group Model HMO; Health Care Prepayment Plan; Independent Practice Association; Medicare Risk HMO; Network Model HMO; Point-of-Service; Preferred Provider Organization; and Staff Model HMO.

Because managed care is a fairly new option in certain parts of the United States, there is considerable misinformation and distrust surrounding it. Through a collaborative effort with another institution, one organization interviewed surveyed 85 seniors prior to a presentation on Medicare HMOs to gauge their level of understanding. The survey found a lack of basic understanding of HMOs, including:

- Some beneficiaries are confused about their current Medicare coverage (as noted above),
- Many beneficiaries do not understand provider network restrictions in HMOs,
- Beneficiaries tend to understand benefits and costs better than risk and quality, and
- Beneficiaries are getting most of their information from HMO marketing materials.

Some beneficiaries simply find the term "Medicare managed care" confusing because they are under the impression that their supplemental insurance policy, with fee-for-service Medicare, is already Medicare managed care. In other words,

"Medicare + Supplemental Insurance Policy = Medicare Managed Care"

in the minds of some Medicare beneficiaries.

It was noted by several respondents that there are regional differences in the levels of general beneficiary understanding of managed care and comprehension of the critical features of managed care. These regional differences relate to the market presence of HMOs and the length of time that an area has been served by HMOs--in higher market penetration areas, there tends to be a higher level of knowledge (beneficiaries tend to ask more complex questions, as opposed to basic ones). In addition, it was noted that members of established plans understand the concepts of managed care, even though the area may have only recently seen an increase in the number of plans available.

In areas where managed care has not been available for any length of time, beneficiaries ask basic questions, such as:

- What is managed care?
- How does it differ from fee-for-service?
- Are there any plans in my area?
- How do I enroll?
- How long does it take to enroll?
- How can I disenroll?

In addition, beneficiaries want to be reassured that they will be able to easily return to fee-for-service. The features of managed care that cause beneficiaries confusion are: the concept of the primary care provider (PCP) as a gatekeeper and the need for pre-authorization or referrals to see a specialist; the concept of being restricted to a network of providers ("Why do I have to see a plan doctor rather than my family doctor?"); the ability to switch PCPs; and the ways to obtain emergency care. To assist beneficiaries, several organizations, including HCFA regional offices, ICAs, and member organizations, expressed a strong interest in being able to provide beneficiaries with comparison tables of the various HMOs and fee-for-service Medicare. Often, however, Medicare beneficiaries ask counselors specifically which plan they should choose, rather than how they should evaluate the plans.

Once a beneficiary has selected an HMO to receive health care services, one of the most common questions is "Why did the Part B premium get withdrawn from my Social Security check when the HMO I selected advertised a 'zero premium'?" Often, beneficiaries do not understand that HCFA is still owed a Part B premium, even if the HMO does not charge one.

In more highly developed managed care markets, some of the complex or technical questions that beneficiaries ask include:

- "Why do different counties charge a different premium for the same services?"
- "What does it mean that one plan is risk-based and another is cost-based?" and
- "Why can HMOs cover prescription drugs and eyeglasses when fee-for-service Medicare does not?"

To further increase the confusion surrounding managed care, preferred provider organizations (PPOs) and point-of-service (POS) features are now being introduced as alternative choices among the HMO options. These features combine aspects of fee-for-service and managed care, confusing the beneficiary who might have just been able to understand the financial implications of going to a non-participating provider. Many noted that these new features will confuse Medicare beneficiaries who have come to understand the distinction between fee-for-service and managed care. However, as knowledgeable consumers age into the Medicare program over the next few years, this information gap should narrow. Many workers are exposed to managed care plans through their employers, and as these individuals become eligible for Medicare, they will tend to know more about managed care than current beneficiaries. The implication for HCFA is that these newer beneficiaries will have different information needs than current beneficiaries, because they will be asking different questions.

Quality of Care

- Beneficiaries tend to inquire about cost more commonly than quality.
- Beneficiaries are starting to seek information about quality of care, in reference to providers and managed care plans, with questions varying by region.

Beneficiaries usually think of "quality" in terms of their own experiences with providers or in obtaining health care. There are a number of recent initiatives to provide consumers with better or comparative information about health plans (using measures like "use of preventive screenings" or "vaccination rates.") Survey and focus group research, however, suggests that many consumers are not yet sophisticated enough to understand the implications of these measures for their decisions. Because of the growth in managed care and the general distrust associated with this delivery option by seniors, beneficiaries are starting to seek information about "quality of care" as well. Some of this interest is also being stimulated by the recent negative media stories that have appeared in newspapers and on radio programs about the quality of care in managed care plans.

We found that beneficiaries' knowledge and perception of quality vary by region. A group of senior citizens in Washington state, for example, wanted information on whether patients are discharged too early from certain hospitals. In Florida we were told that while some beneficiaries understand that it is beneficial for a hospital to be accredited by JCAHO, they do not understand the equivalent concept of accreditation for managed care plans (that accreditation is akin to a "good housekeeping seal of approval"). In addition, although beneficiaries generally know that it is good for physicians to be board certified, they usually cannot explain the concept when asked.

Staying Healthy

In terms of preventive care, the most common theme we observed is the confusion over what services Medicare will cover. For example, many beneficiaries often do not recognize that Medicare covers flu shots, because they have learned over the years that Medicare does not cover preventive shots. In addition, beneficiaries want explicit information on the components considered by Medicare to be included in a "comprehensive physical exam." One health plan we interviewed specifically tracks the questions received through a health prevention/promotion telephone line. The types of questions they receive reflect the areas in which Medicare beneficiaries are seeking information, and include:

- What preventive services does Medicare cover?
- Beneficiaries are interested in such topics as nutrition, exercise, smoking cessation, disease specific support, home safety, and caregiver resources.

- Nutrition: cholesterol, calcium, antioxidants, folates;
- Exercise: how to go about it; where to find programs;
- Smoking cessation;
- Flu shots: where to go, what to do if sick, cost;
- Diabetes: choosing a provider, diet, footcare, exercise; and
- Home safety.

Further, beneficiaries are requesting information on topics such as caregiver resources (assistance at home, meals on wheels, and adult day care), as well as support groups for individuals with specific conditions or diseases.

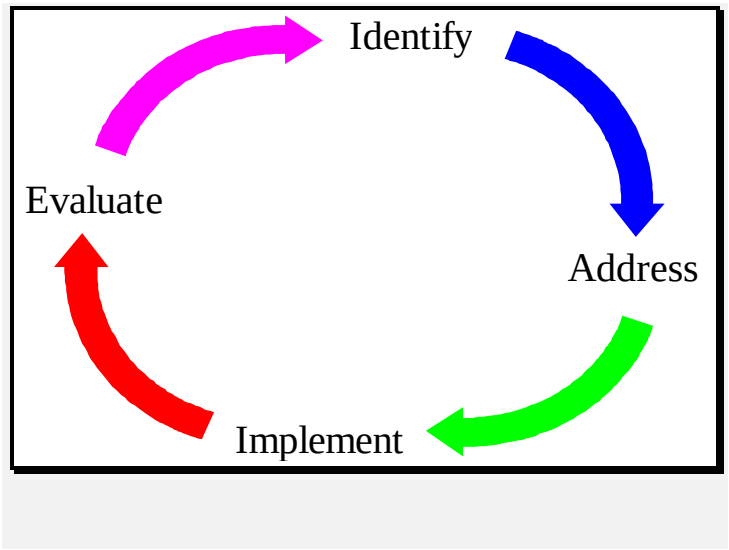
One thing was particularly clear from our interviews: *organizations that work with beneficiaries and the elderly on a day-to-day basis have an important understanding of their information needs and the sources of their confusion about Medicare. Partnering with these organizations to improve its understanding of the information needs of beneficiaries will be an effective and efficient way for HCFA to improve its communication with its customers.*

Strategies and Techniques for Understanding Information Needs of Beneficiaries

Understanding and meeting the needs of beneficiaries, or more broadly, of customers, is important to the success of an organization in serving its target population. This needs assessment process is important to developing procedures that are responsive to the diverse and often divergent information needs of beneficiaries/customers. We interviewed many organizations that have implemented a range of processes for identifying, gathering, and assessing information on the needs of customers served. Our interviews include a broad range of government agencies, non-profit institutions, community agencies, and private companies with varying levels of resources and different strategies for understanding the information needs of beneficiaries/customers. Lack of financial resources and inadequate staffing were cited as the most common constraints on information-gathering processes.

Understanding the information needs of beneficiaries/customers is also integral to an on-going quality management process. Quality management begins with identification, or assessment of customer needs. Once needs have been identified, it is necessary to develop new programs or interventions to address them. During the implementation stage, organizations are usually able to integrate solutions into their organization's existing processes. The next phase of the cycle is to evaluate the success of the program or intervention, by either tracking progress throughout the duration of the program, or by conducting periodic evaluations of the program. The process begins again, as new information needs are identified and solutions are developed. Figure 5 below shows the ongoing and iterative operation of the quality management process.

Figure 5. Process for Quality Management



The collection of data is important to the process of understanding the needs of beneficiaries/ customers. Data collection serves several purposes, including to uncover or understand a particular issue or topic; to use the data to make changes to the program or to summarize the impact of particular interventions. In addition to instituting processes that reveal the information needs of beneficiaries/ customers, it is also critical that quality control mechanisms be implemented to track the improved performance and to assure that these processes become stable and predictable. Many of the organizations we interviewed, such as Xerox and General Electric, had well established mechanisms to track the type of inquires they received in their human resources departments. This information was then used to identify any processes that may have strayed or to provide early warnings of additional information deficiencies requiring intervention.

Seeking input and feedback from beneficiaries/customers regarding their needs was an important common bond among the various organizations interviewed. These organizations used many techniques and strategies, both formal and informal, to understand the information needs of beneficiaries/customers, such as conducting focus groups and surveys with groups of

beneficiaries/customers, tracking information needs from written correspondence or telephone inquiries, and obtaining information from organizations that voice the needs of beneficiaries/customers. Furthermore, many organizations not only collected and tracked information needs, but were also proactive in implementing solutions to identified deficiencies.

Many successful private organizations are committed to customer service and to continuous quality improvement. The vision statements of these organizations often exemplify the company's approach to serving their customers:

- Marriott: "Make people away from home feel that they're among friends and really wanted,"
- Wal-Mart: "We exist to provide value for our customer;" and
- IBM: "Spend a lot of time making customers happy."

Most organizations we interviewed expressed a similar level of commitment, often in their mission statements. For example, the information, counseling, and assistance (ICA) programs were established with the explicit goal of educating beneficiaries about their insurance options. The mission statement of one ICA, the Senior Health Insurance Program (SHIP) is: "To educate the citizens of Illinois about Medicare, Medicare Supplements and Long Term Care insurance. Individuals receive this information through public forums, presentations to various community organizations, senior citizen centers, radio, television and various publications".

The inventory clearly indicates that HCFA needs to incorporate the full cycle of activities into its ongoing operations, and to realize that the process is iterative--the cycle does not have a discrete ending point.

Surveys and Focus Groups

Two structured and direct approaches to gathering data on the information needs of beneficiaries/ customers is to use surveys or focus groups, in which questionnaires and interview protocols are used to obtain consistent information from a pre-determined group of respondents. The private corporations we interviewed were consistent users of both surveys and focus groups to conduct many different types of market research. Surveys are used to gather information broadly, and they lend themselves to quantitative analysis, while focus groups are used to gather in-depth information about a narrow range of topics. Companies, such as GTE, Xerox, and General Electric, reported using these tools most commonly for three purposes: for developing marketing programs for new products; for evaluating the effectiveness of marketing programs or materials; and for obtaining continual customer feedback on programs as they are implemented. Although it is desirable to collect all available information, this approach is often unrealistic due to time and resource constraints. Organizations did try to use random selection to draw samples, and the methodology used was generally as rigorous as resources allowed.

Surveys and focus groups should be conducted at different points in the quality management process. Both are used in the planning stage, in which initial needs identification is the focus. After a communication strategy has been developed, focus groups can be conducted to test

various materials and provide important feedback on their effectiveness. (Prior to the implementation stage, it is important to test materials using a subset of the targeted audience. At this stage, any necessary changes can be made relatively easily.) During the implementation stage, organizations use surveys to assess the experience of the wider audience and make adjustments to the communication strategy where needed. Finally, both methods can be used to evaluate the success of the program in achieving desired goals. Organizations we interviewed varied the extent to which they use surveys and focus groups in each or all of the stages. Those organizations which had the requisite level of resources usually conducted systematic surveys and ran focus groups during each stage.

For example, AT&T has used surveys and focus groups before, during, and after new employee benefit programs are introduced to inform the implementation process. GTE uses both employee focus groups to find out their opinions on managed care and telephone surveys to evaluate their annual enrollment package.

Focus groups are usually comprised of 10 to 15 individuals who discuss issues in an open format. A moderator helps to provide structure and focus to the discussion. Organizations tended to use the groups specifically to pre-test communication or marketing materials, or to gather initial impressions. The results of these focus groups were helpful as they often provided concrete or alternate ways to explain or present concepts before the material was distributed to the broader audience.

For example, the Social Security Administration (SSA) conducted 15 focus groups in seven separate geographic locations to facilitate the development and distribution of the Social Security Initiated Personal Earnings and Benefits Statement (SIPEBES). Focus groups, comprised of members of the general public and SSA employees, were asked to evaluate a SIPEBES prototype. The evaluation covered both the content and format of the statement, as well as the public information activities that accompanied its release. Results from the focus groups indicated that a one-page SIPEBES with a single chart showing both taxes and earnings year-by-year was the preferred format. In addition, the focus groups suggested that SIPEBES should include a comprehensive and simple "Question and Answer" section covering the issues most commonly found to be confusing about the Social Security Program.

Surveys can be especially helpful in assessing the needs of a large and defined population. With a sample of nearly 90,000 enrollees, the Federal Employee Health Benefit Plan (FEHBP) conducts an annual customer satisfaction survey, covering topics ranging from the information needs of government enrollees to satisfaction with materials received from FEHBP. In addition to assessing the needs of customers, surveys can also be used to improve existing materials. In order to assess the information needs of beneficiaries in the state of Florida, Blue Cross and Blue Shield of Florida (the Medicare carrier for both Parts A and B) includes a short survey in their publication, *The Medicare Basic Information Package*, that urges beneficiaries to provide comments on the clarity and helpfulness of the publication. The publication notes that the feedback from beneficiaries will be used to improve upcoming editions. Last year, the Medicare carrier randomly sampled and analyzed 1,000 of the surveys that were returned by beneficiaries. Over 90 percent of

the responses indicated that the publication was useful, easy, and helpful, and beneficiaries would keep the publication and refer to it.

A key point that emerged from our research was that formal, proactive information gathering strategies require a major commitment from the organization, both in terms of resources and possible changes to existing organizational processes.

Tracking Mechanisms

Many organizations and agencies have internal mechanisms to track information on the types of inquiries received from beneficiaries or customers. These mechanisms may be as simple as manually tracking the telephone or written inquiries on tick sheets, or as sophisticated as using computer-based tracking mechanisms.

For example, the Teleservice Pilot program, implemented by the Philadelphia HCFA Regional Office, uses a toll-free number to field Medicare-related calls which are transferred from the Social Security Administration. A pilot database was designed to track teleservice calls and monitor caller satisfaction. The goals of this effort are to document the types of inquiries, examine beneficiaries' receptivity to alternative technology, determine the demographics of the caller population, and identify areas of improvement within the teleservice. HCFA is also pilot testing a software system (Documetrics 2000) to improve the collection and tracking of beneficiary inquiries that come from multiple sources. Though the project has multiple goals, the Executive Secretariat has established a primary goal of reducing turnaround time for response to written inquiries. Two keys to the successes of these and other HCFA initiatives will be the coordination of the various sources of beneficiary feedback and the design of processes to use the feedback to improve customer service. A database of customer feedback will not be effective unless the information is organized effectively, delivered to operational units on a regular and timely basis, and used by those units as part of their routine work processes.

While the feedback obtained from these mechanisms comes directly from beneficiaries/customers or customers, the type of information received through this method is often unstructured and not representative. It does, however, provide a window into the needs and concerns of the beneficiaries who do initiate contact with the organization. The most customer-centered organizations we interviewed provided clear and easily accessible avenues for receiving feedback, with the idea that the customer "knows his or her preferences best." Multiple interviewees made the point that a single 1-800-MEDICARE toll-free number would be easier for beneficiaries to use than the approximately 150 toll-free numbers that are currently in use.

We found that whenever possible, on-going and systematic tracking of inquiries, whether they originate from written, telephone or electronic correspondence, or one-on-one interaction, is the optimal practice. Tracking the information needs of beneficiaries/customers over time allows organizations and agencies to quickly respond to customer inquiries, areas of confusion, or "hot" issues. A tracking mechanism also provides organizations with data that can be used later to assess the success of their interventions and to conduct historical analyses that identify trends or

shifts in the information needs of beneficiaries/customers. The drawback to this activity, however, is that it only captures the needs of those aggressive or angry enough to call.

Well-designed report forms, such as those used by insurance counseling and assistance organizations, are helpful in documenting the counseling session with beneficiaries, and providing the needed data in a consistent fashion. For example, the counseling report from the Illinois Senior Health Insurance Program (SHIP) includes a section that identifies the reason for the contact, such as *questions or problems with Medicare* or *assistance with a Medicare appeal;* a second section that allows more extensive explanation of the consultation; and, sections that provide background information on the beneficiary, such as age and type of insurance coverage. These counseling reports are regularly summarized, and the information used to help identify pertinent issues and to make decisions regarding program operations.

Through the analysis of these counseling reports, it was discovered that beneficiaries had usually sought assistance from SHIP after they had already made unwise health care coverage decisions. The action step that was taken to address this issue was to provide education specifically to soon-to-be retirees. Information regarding SHIP was mailed to soon-to-be retirees which encouraged them to contact the health insurance counseling program if they had questions before making a decision on their coverage.

Many organizations we interviewed track telephone inquiries through computer-based mechanisms which they have recently implemented in their overall effort to improve customer service. Because of the sophistication of computer-based mechanisms, the information gathered not only helps to identify the information needs of beneficiaries and customers, but also provides information to develop indicators and to track them for the purpose of improving the customer service process.

United Airlines, for example, uses a computer-based system that tracks both the types of inquiries received and the profiles of employees who have contacted the Benefits Service Center. Quarterly reports indicate that salaried and management employees generated the most telephone inquiries over time, followed by retired employees. Furthermore, the most frequent call category was "medical/ dental", and the majority of the inquiries concerned coverage

> The United Airlines Benefits Service Center also collects information assessing its customer service activities, which is then used to improve the productivity, efficiency and responsiveness of the center. The computer-based system tracks operational information, such as the overall volume of telephone inquiries, as well as the peak hours of these inquiries, the abandonment call rate, and hold time. United Airlines has been able to establish performance goals regarding the number of minutes that customers are to be left on hold, and the percentage of callers that hang up before speaking to a benefits specialist. The airline then uses this kind of information to fine-tune operations, to make decisions regarding staffing levels, and to identify areas for additional training of customer service representatives.

for spouses and dependents. This information is used to focus further communication initiatives and supplement on-site presentations.

It is important to note that to be effective, organizations must not only have procedures for collecting and analyzing customer/ beneficiary inquiries, but also processes to incorporate the results into ongoing business operations.

Partnering and Local Information Gathering

Because health care is delivered at the local level, information needs vary from community to community, from state to state, and from region to region. Because of this, decentralized information gathering techniques seem to be the most useful for gaining an understanding of the needs of beneficiaries. We found that many of the organizations interviewed have identified the need to establish linkages and partnerships with agencies and organizations that directly serve the elderly community. In addition, most organizations we interviewed seemed to be interested in sharing relevant information either between departments within their organization, and among agencies and organizations with whom they had linkages. For example, ICAs have annual conferences to discuss and share innovative strategies for reaching and serving the beneficiary population.

Many organizations have already established linkages and partnerships with agencies and organizations that directly serve the elderly community. For example, on a national level, HCFA conducts a variety of liaison activities with groups that represent or serve as advocates for beneficiaries. Quarterly meetings are held with national senior organization representatives at which information is shared regarding changes occurring within HCFA and the Medicare program. In addition, HCFA representatives based in Washington, DC regularly visit local senior centers, hospitals, nursing homes, and insurance counseling and assistance programs in various areas to directly hear from beneficiaries about their concerns and needs.

On a local level, Medicare carriers create committees with representatives from different parts of the community called Beneficiary Advisory Committees (BACs) in an effort to better understand the information needs of beneficiaries The BACs are generally composed of individual beneficiaries, representatives from Senior Health Insurance Programs and the area Agency on Aging offices, representatives from other government agencies, members or senior organizations and retiree groups, and HCFA staff.

Some organizations we interviewed did not have formal mechanisms with which to identify the information needs of beneficiaries/customers, but used informal means to gather this information. Unscheduled, casual discussion among individuals who had direct contact with beneficiaries/ customers were important mechanisms used to synthesize multiple impressions on information needs. The insight gained from using the informal mechanisms was then integrated into on-going organizational processes.

The insurance counseling and assistance (ICA) program in Washington state does not currently have a formal tracking system to document volunteers' activities. However the direct contact with consumers during counseling sessions uncovers many important health insurance concerns. The Consumer Advocacy and Outreach (CAO) Division staff conduct frequent meetings with volunteers and sponsors to share observations from the field and to discuss the need for changes or additions to the services provided. This internal communication mechanism keeps the CAO in touch with its consumer audience, so that programs can be developed or adapted to better serve its needs.

For example, through meetings and informal feedback from SHIBA volunteers and sponsors in Washington, it became apparent that the needs of the **disabled** Medicare community were not being adequately addressed through current volunteer and information sessions. The number of specific questions regarding disability and health insurance was increasing, and volunteers were not equipped to answer them, either because of gaps in their knowledge or because they were not personally comfortable with the issues. Once this information need was identified, the CAO developed a SHIBA campaign and volunteer program which would specifically cater to the disabled population, using volunteers who were knowledgeable on these issues and comfortable discussing them.

Communicating Information to Beneficiaries

Various methods of communicating complex information to Medicare beneficiaries, specifically, and to the public, generally, were identified through the interviews. The following discussion of the interview findings on communication methods demonstrates that although tactics and approaches vary across organization in depth and breadth, there are certain fundamental similarities. In order to structure the presentation of this information, communication methods are presented in two ways. The first presentation is independent of organization type and goal, and is a list of the "Overall Best Practices" which are needed to create effective communication. These represent the recurrent themes that we kept hearing throughout our interviews.

Then we present our findings within a format structured using two basic characteristics of communication, namely purpose and tool. The same communication tool might look quite different when it is being used for advertising, for example, from the way it might look if it was being used for targeted information delivery. A printed brochure used for advertising would be designed primarily to get the reader's attention, using brightly colored graphics and minimal text to simply convey a single message. A brochure used for targeted information delivery does not have the sole purpose of getting the reader's attention. It might not contain graphics, it would contain a more thorough discussion of the issue, and it might be distributed at a health fair.

<u>Overall "Best Practices"</u>

We identified several practices that could be used across organizations in designing communication tools for any purpose. Although we interviewed many different types of

organizations in various geographic locations, the following themes were heard repeatedly when we asked how they communicated complex information:

- **Target Distribution** - A general principle of marketing and a main finding of this Inventory Report is that beneficiaries need and want information that is relevant to them. For example, a tenured beneficiary that is about to be discharged from the hospital may want detailed information about the coverage of durable medical equipment under Medicare, whereas a healthy beneficiary might not find that information helpful.

Most people do not utilize information until it is necessary to resolve a problem or make a decision. Timing of information delivery often determines whether or not the receiver will pay attention to it. For example, those about to enroll may need and be able to attend to limited information on the basics of Medicare, how and when to enroll, and the basic choices that individuals will have to make at the time of enrollment. Directing information to those who might need it also helps ensure that it will be attended to, such as an HMO sending flyers about an upcoming healthy heart program to members who have had cardiovasular surgery.

- **Diversify and Sustain Communication Activities** - Individual methods of communication often lend themselves to specific purposes or audiences. For example, methods that are required for "forced" events (enrollment, plan choice, use of acute care services such as a hospitalization) differ from those used for "voluntary" events (use of preventive services, such as influenza immunizations).

  - For "forced" events, clear, concise general information is required regarding the logistics of the event, such as the day, time, and location. HCFA and its partners must then be able to provide tailored, issue-specific answers to the inevitable questions that will arise as beneficiaries attend the event or make the necessary choices.

  - Effective communication for "voluntary" events is both more difficult and more costly. Therefore, these efforts must be carefully targeted by HCFA. To be effective, the audience must be both receptive to the message and able to attend to it. HCFA must integrate a variety of methods that are appropriate for the target audience, and not rely on any single method. Research has shown that effective strategies for increasing the use of specific prevention services rely on a coordinated and sustained combination of televised public information spots, poster/billboards in places frequented by seniors, personal contacts with high risk beneficiaries by a health professional or health plan, and follow-up contact. Because of the expense of this combination of techniques, it is essential to augment HCFA resources with the resources of its partners in the community. Examples of successful efforts include the flu shot and mammography campaigns.

Providing information using a variety of communication methods over time allows beneficiaries to access it using their strongest or preferred learning style--for example, using printed materials, video, and personal instruction, all covering the same topic. Each method reinforces the others, and may appeal to different beneficiaries. Other examples are including mailings with beneficiaries' social security checks or deposit notifications, and a one-page Medicare newsletter that can be distributed through a variety of channels, such as providers, DHS

offices, and community groups. Combinations of methods can be used, such as using one vehicle to raise beneficiary awareness, and another to provide more detailed information.

- **Partner with Local Organizations to Provide One-on-One In Person Communication** - It seems that one-on-one communication, though logistically difficult, is the most effective communication strategy for most elderly individuals. The size of the Medicare beneficiary population makes direct one-on-one contact between HCFA and beneficiaries difficult. However, HCFA does have the opportunity to work through the large numbers of individuals and organizations that come into contact with beneficiaries. The individuals and organizations include not only physicians, nurses, and managed care plans, but also community senior groups, churches, DHS offices, ICAs, and families and friends. Our interviews and the literature both indicate that the notion of **"partner"** is quite inclusive, as these individuals and organizations can be effective sources of information if they have been given the information necessary to understand Medicare. Since personal contact is the elderly's preferred method for receiving information, developing effective strategies for providing **partner organizations** and individuals with sufficient information to explain key aspects of Medicare to clients should be a high priority. Two examples include the Area Agencies on Aging and the Alliance for Information Referral Systems. HCFA currently conducts a number of such activities through the ICAs. Additionally, the HCFA On-Line: Market Research for Providers project may identify ways to improve health partner communications.

New communication technologies, such as the Internet, seem to be most effective when they are interactive and resemble the one-on-one communication preferred by Medicare beneficiaries. Examples of such electronic interactive strategies include: CD ROMs with interactive software that describe specific chronic conditions; on-line user groups or forums devoted to particular illnesses or conditions; and continually updated lists of frequently asked questions (FAQs) about Medicare or health conditions. For beneficiaries who do not have ready access to computers, there are several projects to make health information available in public facilities, such as libraries.

- **Simplify Concepts** - Before any text is written, the material to be communicated should be broken down into its component ideas, and organized in basic conceptual "chunks". This allows the audience to identify each basic concept, around which more detailed and complex information can then be presented. The chunks serve to organize the more detailed information in the recipient's mind. In turn, these "chunked" concepts build a foundation for subsequent layers of more complex information. New concepts, such as "managed care" and "point-of-service" or contradictory concepts, are difficult for an audience to comprehend without mentally sorting through them and categorizing them. Organizing information into manageable "chunks" or single concepts helps the audience to do this, and then make the connections between related concepts. Simplification to a basic or concrete level is crucial for successful and effective transmission of confusing and abstract information, such as health insurance.

- **Simplify Language** - Avoid technical language, jargon, and difficult words. Use active voice and simple sentence structure. Highlight major issues, using short sentences, and elaborate on confusing issues. For example, when insurance terms must be used, provide a clear

explanation, either in a glossary, within the text, or in a margin. Reference to other insurance terms, or potentially unfamiliar words should be avoided. Also, unless previously explained, avoid nesting definitions within other undefined terms (e.g. when explaining the meaning of the term "Primary Care Physician", do not refer to the PCP as the "gatekeeper" without explaining that the "gate" is the network of specialists and that the patient needs a referral to visit the specialist. Most beneficiaries will not automatically know the implications of the gatekeeping function).

With printed materials, the text should be written at an appropriate reading level for the average reader, rather than for the average health services researcher. This not only includes word choice, but the layout of the words on the page. A page of dense text can be as frustrating and difficult to comprehend as words in a foreign language. It is also important to write text that reads similar to dialogue used in everyday conversation.

- **Facilitate Access** - Confusion over health insurance often results from a lack of certain pieces of information as well as a misunderstanding of available information. Communication tools should be developed that are consistent with the target audience's level of comprehension and ability to access the information.

For example, community-based, one-on-one communication strategies are most important for populations with low levels of education. These populations often have language and cultural barriers to general communications, and may also distrust non-community-based efforts. In a one-on-one format, communication can be directed to the particular information gaps and sources of misunderstanding that are specific to the audience.

- **Simplify Interaction** - Medicare beneficiaries receive information about the program from a variety of sources including HCFA materials, friends and family, healthcare providers, senior groups, churches and civic organizations, and their health plans. Often, the first source refers them to a second, and a second refers them to a third, and so forth, before the beneficiary is finally able to obtain the specific information he or she needs. By this time, the beneficiary is often too confused or frustrated to be able to take in or process the information. We found that providing a simple process for the beneficiary to arrive at the appropriate information source reduces confusion and facilitates comprehension of the information. This principle is akin to "one-stop-shopping."

Most of the large and innovative companies we interviewed have instituted a single toll-free number for all health benefit information. Both the interviews and the literature review suggest that Medicare beneficiaries also want a single 1-800-MEDICARE type of number. The elderly prefer to speak to a live operator, rather than use an automated voice tree. However, what appears most important is that the caller speak to a live operator quickly, that the first operator be able to answer most questions directly, and that any referral be made for the caller within the call, so that the caller experiences it as "seamless." One large company uses two different toll free numbers, one with a telephone tree for younger retirees, and one with a human operator for retirees 80 years of age or older.

Purpose of Communication

HCFA should take two factors into consideration in designing its communication strategy: the reason for conveying the information (purpose), and the tools that can best be used to convey it. Communication purpose can be divided into four areas as described in the research literature (Novelli, 1988). These areas provided a framework for organizing the many activities we discovered in the interviews. They include:

- Advertising,
- Targeted information delivery,
- Promotion, and
- Person-to-person exchange of information.[17]

HCFA's optimal communication strategy may involve a mix of activities within each of the four distinctly different purposes listed above. Furthermore, an optimal strategy for HCFA might use a variety of communication methods or tools within each purpose, although certain ones particularly lend themselves to certain purposes, such as using television or radio to advertise.

Just as information gathering strategies can be divided into proactive and reactive strategies, communication activities can similarly be divided into non-interactive and interactive, with both types employed for each purpose. Table 3 summarizes the ten activities included in HCFA's current program of customer service[18] by the type of activity and the communication purpose to which it seems suited (McCormack et al., 1996). Due to its flexibility, computer technology will likely be used for all purposes as new generations of computer-literate beneficiaries become eligible for Medicare.

Table 3. Current HCFA Communication Activities by Purpose

Communication Activity	Advertising	Targeted Information Delivery	Promotion	Person-to-Person
Non-Interactive Activity				
Television	X			
Radio	X			
Video	X	X		
Audiocassette	X	X		
Print Media	X	X	X	
Electronic Message Board/Billboard	X	X	X	
Interactive Activity				
Individual Written Communication		X	X	
Community Outreach Services	X	X	X	X
Telephone		X	X	X
Computer/ Internet	X	X	X	X

Source: HCFA Project Customer, 1995

Advertising

Advertising mostly involves using the media to communicate a simple message to a broad audience. We found a definite distinction between beneficiaries who have never heard of particular aspects of Medicare (where HCFA advertising efforts have failed to reach them) and beneficiaries who are confused about certain aspects of Medicare (where education efforts may not have been able to overcome barriers and to communicate a clear message).

One important component of advertising is visibility, especially among private corporations, insurers and managed care plans, and some government agencies (such as the Social Security Administration). Interviewees described efforts to create the impression of a strong local presence, often using field or branch offices in local communities. For example, Merrill Lynch uses a system of storefront sales offices located across the United States, and specifically directs advertising efforts to create an image of "a trusted and knowledgeable neighbor" for the Merrill Lynch sales representative. The Social Security Administration (SSA) has offices scattered throughout the country, and while beneficiaries often do not know of HCFA, they do know of SSA.

Beneficiaries are currently receiving very little advertising from HCFA, and a considerable amount of advertising from certain other entities, such as the more aggressive managed care organizations. As a result, beneficiaries are often confused by the messages they receive about Medicare, because the Medicare message is interwoven with the marketing message of the organization. Advertising activities virtually always use the media, such as newspapers and print, television, radio, billboards, etc. These activities can be either commercial or in the public interest, depending upon whether the air time is bought or donated.

Advertising activities can also include the placement of stories and articles in newspapers, spokespersons on television and radio, and programs at conferences or events. These informational activities communicate longer and more in-depth messages than advertising, and often add message credibility because they are embedded within other media. The attached credibility of the source can also be used to create a specific impression. Name recognition can also be enhanced using such strategies, because the audience is basically self-selected due to their interest in the surrounding media format. Combining single message advertising with activities that piggy-back on other methods can be especially effective in presenting complex information. The simple message initially creates "cognitive hooks" which enhance audience understanding of the subsequent longer message. For example, the Institute for Puerto Rican and Hispanic Elderly uses a combination of flyers, then public service announcements and finally, one-on-one or small group interactions.

Many local organizations serving Medicare beneficiaries, such as the SHINE program in Miami, reported that, often, the questions they receive are in response to articles that have recently appeared in newspapers, radio programs, or programs seen on television. Advertising can often be used as part of a more comprehensive communications strategy. For example, a campaign to increase the use of Medicare-covered preventive services, such as flu shots, may include a

television commercial or bulletin board as a "hook" to get beneficiaries' attention. Other forms of communication, such as brochures in doctors' offices, pharmacies and senior centers can serve to provide the detailed information beneficiaries need to take positive action.

Targeted Information Delivery

Targeted information delivery activities are communications directed toward a specific subset of the audience, and are useful for reaching identified subgroups. A general principle of marketing, and a main finding of this Inventory Report, is that beneficiaries need and want information that is relevant to them. For example, a tenured beneficiary that is about to be hospitalized will want detailed information about the coverage of hospital services under Medicare, whereas a newly-enrolled and healthy beneficiary might not find that level of detail helpful and will likely be confused by it.

Targeted delivery activities particularly lend themselves to building linkages with other organizations in the community. The beneficiary audience is first subset by its affiliation with the organization, and has a natural interest in the materials that are distributed through the organization because of their prior connection to it (e.g., AARP, local community organizations, churches). For example, the National Caucus and Center on Black Aged has found that the easiest way to publicize a new organization is to harness existing community groups, such as local area churches.

Partnering for targeted delivery can also occur naturally through providers. Currently, many physicians distribute pamphlets about Medicare, along with other informational materials. Time-Life Medical distributes its videos on health through 22,000 pharmacies nationwide, with the idea that while seniors are waiting to have a prescription filled, they will have time to read over the materials accompanying the videos.

Promotion

Promotional activities are used to build on other communication techniques in order to activate a particular behavior. Offering free samples, conducting sweepstakes, and providing coupons are examples of common promotions designed to induce the consumer to buy a particular product.

One example of a promotion might be giving a beneficiary a Happy Heart cookbook for participating in a cholesterol screening. An integrated communication strategy for this cholesterol screening might include: (1) advertising the upcoming screening in the local newspaper to publicize it widely; (2) submitting a letter to the editor about what cholesterol is and why it is important, possibly including the difference between HDL and LDL and how it is important to know one's levels of each--the letter would reach those beneficiaries who are interested in the topic (informational advertising); (3) having the local hospital distribute leaflets about the screening in their cardiac unit (targeted delivery); (4) giving away the free Happy Heart cookbook to all those who participate (promotion). An example of an organization we interviewed that uses promotional activities regularly is Av-Med, an HMO in Miami, that sponsors regular social activities for seniors such as mall walks and picnics. Medicaid managed care companies are also a

source of information on effective promotions used to reach and encourage healthy behaviors among vulnerable populations. Keystone-Mercy Health Plan of Philadelphia, for example, gives a good quality baby stroller to each pregnant enrollee who completes the Plan's pre-natal course.

Person-to Person Exchange of Information

The most direct and dynamic way to deliver information is through a person-to-person exchange, such as having one's question answered by an operator on a toll-free telephone number. This type of communication activity provides an opportunity for feedback and a mechanism for tailoring the message to the listener.[19] An important finding of this research is that beneficiaries like to talk to a live operator and have their individual questions answered. Person-to-person exchange occurs regularly throughout one's daily routine and is the optimal vehicle for delivering complex information, such as insurance options, and assisting beneficiaries in making choices.

Additionally, this method facilitates playing the multiple roles we observed among organizations serving seniors, such as information "broker," counselor, and advocate. The PRO in Miami, for example, conducts small group presentations at local senior centers. Seniors can ask the speaker questions, and these questions can in turn help direct the activities at the center, such as providing help to beneficiaries with their Medicare paperwork.

The drawback is that this particular method can be labor-intensive and limited in reach. For example, one ICA reported that it served only 1 percent of seniors in need of its services. Seminars and small group presentations are other examples of this method. Partnering with organizations having specific technical expertise can be a particularly effective way of increasing the reach of this type of communication with beneficiaries, who often are in need of specialized assistance, such as legal advice. The Washington DC ICA is housed in the George Washington University Law School, and law students often assist beneficiaries with legal matters on a person-to-person basis.

Communication Tools

Once the purpose for the communication has been established, the second step in developing a communication strategy is choosing the appropriate communication methods or tools. The tools listed below represent a catalogue of those used most frequently by the organizations and companies interviewed. Since all can be effective, it is difficult to provide a ranked order of "best practices." Instead, they are grouped as non-interactive or interactive, with some of the suggestions we received accompanying the text.

Non-Interactive Communication. Non-interactive communication tools are ones that are used to provide a one-way delivery from the information source to the recipient. These tools include printed materials, video, and the full gamut of media (television, radio, movies, newspapers, magazines, electronic bulletin boards). The recipient controls how he or she accesses the information with some non-interactive communication, for example, printed materials can be read and reread or used for reference.

⇒ Printed Materials

The most widely used communication tool, printed materials, encompass a variety of formats. These include brochures, newsletters, pamphlets, booklets, handbooks, fliers and postcards. We include some materials collected from the interviews which are particularly good examples of clear and concise layout and language at the end of this chapter. Each format has particular advantages and is more effective when communicating certain types of information. For example, brochures and pamphlets are well suited for explaining a single topic such as "Limiting Charge" or "Fraud/Abuse," while handbooks and booklets are better formats for more comprehensive information, such as a description of the Medicare program or Medicare Managed Care. For example, the SHINE program, a Miami ICA grantee, distributes fact sheets on single topics. In addition, some formats, such as postcards and fliers, can be used to preface the arrival of a larger packet of information or to advertise upcoming events and services. AvMed Health Plans uses return mail postcards for seniors to RSVP to their events. Most interviewees suggested using the features presented in the box regarding layout and presentation in the materials. We also observed these features in the sample materials we were given (see Appendix III for examples of printed materials).

- Plenty of white space on the page
- Bullet format or short sentences
- Large readable print; 12 point or larger
- Definitions of important terms either highlighted or in margin; avoidance of jargon or highly technical terms
- Maximum 7th grade reading level
- Clear contrast in colors when used for text
- Charts, pictures and graphics should supplement or replace text when possible
- Step-by-step or process oriented presentation of enrollment or decision-related information
- Second person voice for material text, when appropriate (e.g., Your Medicare Benefits)
- Tabular form or well marked indices for booklets and handbooks

⇒ Video

The video format, which can be expensive, allows the viewer to absorb information through television, capitalizing upon both the visual and oral transmission of ideas. Video allows for multiple viewing, or for stopping to repeat segments. Though not an interactive tool, video, like television programs, can achieve a unidirectional flow of information with the illusion of it being a person-to-person flow of information. Often, the beneficiary relates better to

- Clearly organized video with brief overview at beginning.
- Time limited - no more than 30 minutes
- Written supplement which follows the format of, or makes reference to, the video
- Use shots of people "like me" in the video

information transmitted by a human being than information transmitted in written format. Time-Life Medical makes and distributes 30 one-half hour videos featuring former U.S. Surgeon General C. Everett Koop, each on a particular diagnosis and how to manage it. Since video is perceived as an expensive undertaking and HCFA is a public agency using tax payers' money, it is vital to provide framing for the video in order to contextualize it for the viewer. Framing can include communicating the purpose, the cost, and the justification for using the video. One large private sector employer blanketed its employees with a video cassette on the company's benefits. The reaction from employees was, "Why is the company spending all this money on video cassettes at a time of corporate downsizing?" Even though the unit cost of the video was quite inexpensive, employees had a negative reaction because the cost information had not been provided to them in advance. Because HCFA has access to in-house production staff and facilities, the unit cost of making videos can be low, making video a cost effective vehicle for providing information to beneficiaries. An example of a particularly effective HCFA video is *How to Choose a Nursing Home.*

⇒ Media

- Use local newspapers or bulletins which target the intended audience
- Provide radio shows with the opportunity for listeners to call-in

Media is central to our society, and can be a powerful tool when used effectively. Most of the private organizations interviewed used media extensively to market their products. The media is widely used for advertising, such as with print ads or commercials, or can be used as an in-depth information source, such as with newspaper columns and radio shows. Using media is a way to stimulate public discussion and frame the way individuals think about an issue. Media can be used to reach a broad audience, or can be targeted to particular audiences by buying air time in particular markets and time slots. Two suggestions were made during the interviews as ways to harness the enormous power of the media and direct the message to a targeted audience: (1) to use local community newspapers, preferably in the language spoken by most of the residents; and (2) to introduce interaction into the communication wherever possible, such as on a radio show where listeners call in on the air with questions and comments.

Interactive Communication with Beneficiaries. Elderly individuals especially respond well to interactive communication, as a comfortable and controlled setting can often be provided for them to voice their individual concerns and solicit advice. Because beneficiaries receive large quantities of complex and difficult written material regarding Medicare, communication through individual counseling or telephone hotline is often crucial for a beneficiary to properly understand the information and use it to make appropriate health care decisions. The ICAs provide an excellent example of the use of this tool in that they can function in a variety of roles, depending on beneficiary need. Some beneficiaries need to know where to find information while others require in-depth counseling or advocacy, both of which can be, and often are, provided by the ICA.

⇒ Toll-Free Telephone

Most large companies use a single toll-free number for all health benefit information, and both the interviews and literature review suggest that this method is also effective with beneficiaries. While the majority of individuals have used a toll-free number to obtain information, the elderly especially prefer to have a live person to answer their call, rather than an automated voice tree.

- ♦ Menu driven with operator opt-out
- ♦ Keep instructions for operator default at the beginning of the automated menu
- ♦ Well trained operators with age-sensitivity and empathy skills; keep referrals to a minimum

Many beneficiaries are currently either unaccustomed to communication technology systems, such as menu driven teleservice, or have rotary dial telephones instead of touch-tone. As the next beneficiary generation becomes Medicare-eligible, dependence upon live operators should decrease. Telephone information lines are used for a variety of purposes by most organizations, from delivering information about the organization and its functions, to providing advocacy and counseling services to callers. As with anyone working directly with seniors, operators should be well-trained; should be age-sensitive and empathetic; and should keep referrals to a minimum, handling issues in-house whenever possible. Hold time should be kept to a minimum. Also, when using a menu-driven system, instructions for operator default should be listed at the top of the menu options in order to avoid hang-ups from callers who only want to speak with an operator.

Partnering with providers can considerably increase HCFA's reach using this method. Of the health plans and carriers we spoke with, all had a dedicated number for plan members and beneficiaries to call with questions about services, enrollment and disenrollment, health advice, or status change. We also found that the advocacy oriented lines, usually run by ICA grantee programs or senior groups, like AARP, are more likely to have live representatives rather than an automated menu on their lines.

⇒ Volunteers

In addition to being knowledgeable about health care and related issues, volunteers must also understand the beneficiary population and the specific needs of sub-populations within it. Beneficiaries seem to respond well to those who are similar to themselves, either in age, ethnicity, or physical ability. We saw several examples in which the use of volunteers was especially powerful. The SHIBA program, the Washington State ICA grantee

- ♦ Able to probe into a beneficiary's question to uncover larger issues or underlying problems
- ♦ Use a comprehensive case intake sheet for each introductory session in order to maintain continuity of information for any subsequent counseling

program, recognized an advocacy need from the disabled Medicare population. Because disabled beneficiaries responded particularly well to disabled counselors, a separate program was created using only disabled volunteers for counseling and one-on-one sessions with beneficiaries.

Both AvMed in Miami and GHCPS in Seattle, make use of senior volunteers in many of their activities as they have found that senior members often are more comfortable sharing personal information with their peers.

In order for volunteers to be most effective, ongoing support should be provided by the organization. For example, using a comprehensive case intake sheet for each introductory session with a beneficiary and keeping it on file allows the organization to provide a continuity in the information that might be needed for any subsequent counseling. Volunteers should be supported so that they are comfortable enough to probe into a beneficiary's inquiry to uncover the larger issues or underlying problems. For example, one HMO enlisted a senior volunteer to design a computer database of useful information that volunteers can access by topic.

⇒ Seminars/Information Fairs

- Promote as a social event
- Hold in an easily accessible, central location
- When possible, use a speaker who can personally relate to the audience (e.g. through ethnicity, age or disability)
- Provide opportunity for questions and answers

This communication tool provides a forum for small group discussion and individual questions within a person-to-person setting. Usually organized by health plans and private companies, seminars and information fairs provide a social and pleasant environment within which to learn about complex information, such as health insurance and benefits. When possible, a speaker who can personally relate to the audience (e.g., through ethnicity, age, or disability) should be used, and an opportunity for questions and answers is often helpful. General Electric uses a "benefits expo" as a way for retirees to obtain information on managed care. In addition, they are very aware of the "word of mouth" channel of information distribution in each interchange with a beneficiary. Beneficiaries are likely to pass along information, positive or negative, to other beneficiaries.

⇒ Technology/On-Line

Technology driven tools, such as computer innovations, will be better received by the next generation of beneficiaries. While a subset of beneficiaries do not have access to a computer or the Internet, there are many who actively seek out access through family members or local libraries and universities. Some innovations that organizations reported using include:

- Intranet or E-Mail - Used mainly by corporations to communicate internally with their employees. An application for HCFA would be to have access to the employed population, many of whom are actively involved in taking care of elderly family members and may have general questions about Medicare or more specific information needs, such as options for long-term care. Additionally, HCFA could communicate more easily with the employed under-65 population, a group that has typically been hard to access.

- E-Mail - Used mainly by corporations to communicate with employees about upcoming information sent via mail; or to advertise upcoming events
- Internet - One-stop shopping for information with links to related information. See Time-Life/IBM Health Village, GE, HCFA homepages
- Kiosks - Like ATM machines for Medicare enrollment or claims information (Philadelphia Regional Office's Medicare Center Pilot Project)

- Internet - Can be a source for "one-stop shopping" for information, with links to related information, such as the HCFA homepage. A possible application for HCFA is to have links with its partners, so beneficiaries can easily move among sites to obtain specific information.
- Kiosks - Similar to ATM machines, can be used for Medicare enrollment or claims information. Kiosks are currently being used in the Philadelphia HCFA Regional Office's Medicare Center Pilot Project, and among private corporations, by Motorola to provide benefits information to employees.

New technologies are continually being developed that make electronic communication more interactive, and, in some ways, resemble the one-on-one personal communication preferred by beneficiaries. The Time-Life/IBM "Health Village" is an example of an Internet information site that is easy to navigate and provides a wealth of information to the Internet user, including a medical library and links to the home pages of various health care organizations. Other examples include the Comprehensive Health Enhancement Support System (CHESS) developed at the University of Wisconsin and Compuserve's Health Answers. As these techniques develop and more beneficiaries have access to the means to use these tools, on-line and other technologies will grow in importance to HCFA in the implementation of an integrated communication strategy.

Current Sources of Information Used by Beneficiaries

As we found with information needs and communication methods, the sources beneficiaries currently use to obtain information on Medicare varied widely, depending upon the beneficiary's age, functional status, the proximity of family members, ethnic or racial minority status, educational level, and whether he or she lives in an urban or rural area.

The information obtained in our interviews suggested that beneficiaries use a wide variety of sources of information on Medicare, such as providers, friends and relatives, Social Security offices, senior centers, and many call the Medicare departments of their insurance companies. This finding confirms studies in the research literature, which also found diversity in beneficiaries' sources of information. For example, while television is a widely used and preferred media form (one study found that seniors spend an average of two and one-half hours watching television per day), we heard that seniors are more likely to read newspapers than other age groups, so some insurers reported that they often place letters to the editor in local newspapers on topics of interest to their members. In Miami, some Hispanic populations who recently immigrated to the US prefer to listen to radio shows, since radio was widely used in their countries. In New York, we were told that older beneficiaries (over age 75) tend to receive most of their information from staff in their physician's office.

An interesting finding of the literature that seemed to correspond to our observations was that seniors like to receive information by word of mouth, or in person-to-person interchanges. One HMO (AvMed) dedicates three separate departments to work with seniors, one of which is a designated ombudsman whose primary goal is to advocate for the beneficiary. We observed staff at a Miami senior center following up the PRO's presentation by speaking with almost half of the seniors individually, who had each heard the presentation, explaining the procedures of Medicare appeals process. Although many had the same questions, they each seemed to want to be able to ask their question and hear the particular answer directed to them.

Seniors often have more free time than other age groups, and many who live in urban areas take public transportation. One ICA staff member suggested advertising the Medicare hotline or the ICA using ads in buses or bus stops because so many of the beneficiaries served by the ICA take the bus.

An important issue for beneficiaries is being able to trust the source. Many interviewees that work directly with seniors told us that often beneficiaries do not trust the managed care marketing materials they receive, preferring to hear about the plan from a friend or relative. A surprising finding is that some beneficiaries do not trust AARP, because of the advertising that insurers place in publications like *Modern Maturity*. Many beneficiaries, especially ethnic minorities and immigrants, do not trust government and are afraid to seek information from a government agency.

We heard fairly regularly that beneficiaries seem to like to receive fact sheets on a single topic, from local Social Security offices to ICAs to carriers. Many reported that the Medicare Handbook is presented in a more complex format than most beneficiaries can comprehend, although we did hear that many seniors use it as a reference, supplementing the information they have received on a fact sheet.

Summary and Discussion of Interviews

The interview component of the inventory provided a wide range of expert opinion regarding the information needs of seniors and the best communication strategies to use with different groups of them. Organizations interviewed included regional HCFA offices, local Medicare advocacy and counseling programs, Medicare carriers and fiscal intermediaries, Medicaid and Medicare managed care plans, Federal agencies, and private corporations. We performed structured interviews in and around Washington, DC, and in cities chosen to represent different geographic regions with large Medicare populations, such as Chicago, Miami, New York, Philadelphia, and Seattle.

We found a high degree of variance in the information needs of beneficiaries, with considerable confusion regarding managed care. We found differences between beneficiaries who had never heard of a particular aspect of Medicare and beneficiaries who were confused by the information they had obtained. In this case, two separate interventions seem to be warranted: strengthening the advertising of the feature, by broadening the reach or using local in-language media, versus simplifying the message or providing concrete examples using targeted delivery or public relations activities.

We found a range of mechanisms for gathering information on the needs of beneficiaries or customers, ranging from proactive and structured surveys and focus groups to informal, unstructured, or reactive mechanisms, like responding to customer inquiry or ad hoc staff discussions. The needs of the organization usually dictated the choice of activity, with the level of resources and organizational mission exerting the greatest influence. Clearly, the need to incorporate the results of information gathering, tracking, and analysis into organization' on-going business operations, is a key to improving communications and customer service.

We found a plethora of communication methods across the interviews. We identified four basic purposes for communication: advertising, targeted information delivery, promotion, and person-to-person exchanges of information. Many communication tools are used by most organizations, with certain tools better suited to certain purposes. We identified a set of "best practices" that could be applied to any purpose or tool, most of which involved simplifying the presentation or conceptual framework of the message.

While HCFA is currently using most of the methods we found through the interviews, there is room for better integration and synthesis of activities to underpin the communication effort. The development of the MTS will facilitate many of the practices that were found to be repeated refrains throughout the interviews, especially ones in which personalized data on the beneficiary is needed for the intervention.

The best use of the interview findings is as a starting point for more detailed inquiry or planning. The iterative nature of the work on HCFA On-Line Market Research for Beneficiaries allows each phase of the research to inform subsequent phases--in this case, findings from the interviews

served as scaffolding for developing the protocols for the focus groups, in which more detailed information can be collected directly from beneficiaries.

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